Rhode Island Medicaid Program

Annual Report
Fiscal Year 2005

health care programs to meet diverse community needs

long term care initiative • pregnant women • breast and cervical cancer program

TBI implementation grant • elderly adults • aged and disabled waiver program

PACE grant • RIte Care for children and families • chronic care programs

drug utilization review • State Health Insurance Program Title XXI • medical transportation

adults with disabilities • nursing facility transitions grant • children under age 19

real choice systems change grant • CEDARR family center • RIte Share

lead centers • children with special health care needs • foster care initiative

MESSAGE FROM THE DIRECTORS

Access to appropriate, effective health care remains a priority in Rhode Island. Rhode Island Medicaid cares for some of the state's most vulnerable populations and is an integral part of the state's overall health care system, serving 18 percent of Rhode Islanders.

The Department of Human Services produces the Medicaid Annual Report to provide the legislature, the administration and the public with information that will help these groups make informed decisions about Medicaid services and programming. The three sections of this year's report describe:

(1) Medicaid's structure, financing and eligibility rules; (2) the programs, populations and expenditures overseen by DHS' Center for Adult Health; and (3) the programs, populations and expenditures overseen by the Center for Child and Family Health. In addition, under 2004 requirements of RI General Laws Section 42.12.27, the report includes a focus on sub-populations within children with special health care needs, including: children in substitute care, children covered through SSI or the Katie Beckett eligibility provisions and children in subsidized adoption. The report covers all Rhode Island Medicaid expenditures, including those made through other state departments and local school districts.

In State Fiscal Year 2005, Medicaid spent $1.8 billion in state and federal funds to provide health care services to an average of 185,899 people each month. Medicaid provides access to health care for a range of populations including: elderly, persons with disabilities, children and families, and children with special health care needs.

Adults with disabilities and the elderly account for 25 percent of the Medicaid population and 66 percent of total expenditures. The 25,820 adults with disabilities enrolled in Medicaid in fiscal year 2005 represent a two percent increase from 2004, while the elderly population increased less than one percent to 19,784. Overall, the expenditures for the adult population with disabilities under age 65 reached $599 million in 2005, an average of $1,869 per capita per month. Over $441 million was spent on services for the aged, with an average monthly per capita cost of $1,787.

Efforts to stabilize the growth of the successful RIte Care program continued in fiscal year 2005 as RIte Care eligible children and families were enrolled in employer-sponsored health care coverage through RIte Share. By enrolling children and families in RIte Share, the state pays only the employee portion of the employer-sponsored premium instead of 100 percent of the premium under RIte Care. Total expenditures for 125,060 children and families in RIte Care and RIte Share were $345 million in fiscal year 2005. The average monthly per capita expenditure (including in-plan and out-of-plan services) for RIte Care was $227 and for RIte Share, the average monthly per capita expenditure was $117. Overall, an average of 15,235 children with special health care needs were Medicaid eligible each month in fiscal year 2005. Total Medicaid spending on this population rose to $212 million, with an average monthly expenditure of $1,446 per child.

Rhode Island Medicaid continues to work hard to meet the challenges of improving the health and health care of the state's most vulnerable populations. The Department of Human Services and its partners are committed to increasing access and quality of care while containing costs, as we continue to build health care programs to meet diverse community needs. ■

Jane A. Hayward
Secretary
Executive Office of Health & Human Services

Ronald A. Lebel
Acting Director
Department of Human Services

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INTRODUCTION, ADMINISTRATION & OVERVIEW

The Rhode Island Department of Human Services produces the Medicaid Annual Report as part of its role as the designated agency responsible for Medicaid. The Rhode Island Department of Human Services (DHS) is the Medicaid single state agency responsible to the federal government and the state for the effective, efficient administration and supervision of Rhode Island Medicaid and for assuring statewide accessibility to a comprehensive system of high-quality health care services for Medicaid recipients.

The Department began compiling an annual report on Medicaid in fiscal year 1999. The report was prepared in response to a request from state policymakers for additional information about Medicaid expenditures to assist in evaluating program outcomes and promote greater fiscal accountability.

Using information from fiscal year 2004 for comparison, the fiscal year 2005 annual report provides updates on changes in Medicaid populations and program expenditures. The report highlights the activities of the Center for Adult Health (which serves adults with disabilities and the elderly) and the Center for Child and Family Health (which serves children and families and children with special health care needs). The report outlines current program services and initiatives, summarizes health care expenditures and utilization rates and describes efforts at measuring access, quality and outcomes.

Rhode Island has seized every opportunity to use the greater flexibility the federal government has given the states over the past ten years, expanding access to and improving the quality of Medicaid health care services and coverage. The state has made particular efforts to extend coverage to new population groups in order to improve health care outcomes and decrease the rate of uninsurance in the state. While Rhode Island, like other states, has seen an increase in the number of uninsured residents, efforts to provide insurance coverage have helped to keep the uninsurance rate lower than in other states. In 2004, Rhode Island's rate of uninsurance was 11.4 percent. Unfortunately, Rhode Island's ranking moved down to ninth, from second lowest nationally, the previous year. This increase in the number of uninsured resulted from reductions in employer-sponsored coverage. In addition, Rhode Island has used its Waiver authority to provide specialized services to individuals who can benefit from them. These efforts have improved the lives of many adults with disabilities and elderly individuals who now have the option to obtain care in the community rather than in institutions.

When Medicaid began in the mid-1960s, the program was modeled on the indemnity health insurance plans that dominated the private market at that time. Under this "fee-for-service" model, Medicaid became a payer of medical claims incurred by its beneficiaries. A Medicaid recipient first identified a provider who would accept Medicaid's "fee-for-services performed" and then went to the provider for care. The provider submitted a bill to Medicaid, which Medicaid then paid. While some argue that a passive role is the natural order for a government-run program, others contend that this approach ignores the state's considerable potential to leverage the program's spending volume. This leverage enables Medicaid to conduct value-based purchasing in order to optimize the balance between the quantity, quality, and cost of services.

INTRODUCTION - CONTINUED

Throughout the 1990s, the Rhode Island Medicaid program, like others across the country, leveraged its purchasing power to transition from "payer" to "purchaser." Value-based purchasing involves contracting upfront with an organization that accepts payment for an agreed upon price for a specified service or range of services to Medicaid clients. The state, as the purchaser, sets standards (e.g., quality of care standards) for which the contracting organization is held accountable.

As a purchaser, the state can obtain services for all clients or subgroups of clients. The state can purchase one service, a specified range of services, or all Medicaid covered services. It can contract with one or many organizations/providers as needed. This process requires the state to develop and enforce contractual standards for health care quality and access. Value-based purchasing necessitates a good quality management system, including negotiated performance measures, member satisfaction surveys and focus groups, independent external reviews, data reporting and analysis, and continuous quality improvement systems.

Over time, RI Medicaid has been shifting from being an after-the-fact payer of services to a value-based purchaser that can leverage its buying power to secure better and more cost-effective services and delivery systems for enrollees. This value-based purchasing principle enables Medicaid to promote better outcomes for the consumer and to gain more overall value for the public dollar.

Rhode Island Medicaid has also made changes to the range of populations it serves and the service delivery options it offers. Although Medicaid served a fairly limited population at its inception, state programs have been given incremental leeway to expand the individuals and families they cover. Rhode Island has chosen to provide Medicaid coverage to a number of optional groups. States can provide optional services, for which they receive federal matching funds.

The federal government requires the states to provide all Medicaid recipients with services that are comparable in scope, amount and duration. In the early 1980s, states were given the option to waive this and several other Medicaid requirements. Rhode Island established its first two Waivers in 1983, and now administers six Home and Community Based Services (HCBS) Waiver programs.

Rhode Island also administers a Section 1115(a) "research and demonstration" Waiver. Section 1115(a) Waivers allow states to explore new approaches to benefits, services, eligibility, program payments and service delivery. In 1994, Rhode Island used a Section 1115(a) Waiver to implement RIte Care, the state's Medicaid managed care program for eligible children and families and for children with special health care needs. ■

WHAT IS MEDICAID?

Medicaid is a federal/state sponsored health care program for individuals and families with limited incomes and resources. The program was established by the federal government in 1965 as Title XIX of the U.S. Social Security Act.

In the years since the program was created, Medicaid has become both the primary payer and purchaser of health care for many individuals and families in need. Today, Medicaid is the chief source of funding for: long-term care for individuals with limited-means; health care services for low-income adults with disabilities; and health care coverage for low-income families and their children and pregnant women and infants.

The federal government establishes core requirements concerning Medicaid funding, eligibility standards, and the quality and scope of medical services. Medicaid is an entitlement program; anyone who meets specified eligibility criteria may receive Medicaid services. Within this structure, states have flexibility to determine certain aspects of their own programs in the areas of eligibility, reimbursement rates, benefits and service delivery.

Title XIX requires that each state maintain a Medicaid State Plan that identifies the populations served, the criteria for determining eligibility, the scope of services provided, and the method of service delivery. The Medicaid State Plan is submitted for approval to the U.S. Centers for Medicare and Medicaid Services (CMS), the federal agency with oversight responsibility for state Medicaid programs. The Medicaid State Plan is an evolving rather than fixed document. A state must continually amend and/or revise its state plan to reflect the changes made in Medicaid program priorities and requirements.

Federal law also requires each state to centralize administrative, legal and financial responsibility for its Medicaid program in a "single state agency." The unit of government designated as such maintains the Medicaid State Plan, purchases the health care services and coverage authorized therein, and coordinates their delivery statewide. In Rhode Island, the single state agency is the Department of Human Services.

The Balanced Budget Act of 1997 added a new section to the Social Security Act - Title XXI. Title XXI established the State Children's Health Insurance Program (SCHIP), a federal/state program designed to provide health insurance coverage to previously uninsured children. Each state designed its own program within established federal guidelines. Rhode Island built on its previous expansion of child and family coverage by using SCHIP funding to expand its existing Medicaid program to cover more children.

For a detailed history of the Medicaid program see the DHS website www.dhs.ri.gov ■

ADMINISTRATION OF RHODE ISLAND MEDICAID

The Department of Human Services is the designated single state agency with responsibility and accountability for the Medicaid program in Rhode Island. As the single state agency, DHS has statutory responsibility for:

1. **Oversight of the Medicaid State Plan.** The DHS must administer or supervise the implementation of all aspects of the Medicaid State Plan, including ensuring the correctness and accuracy of all financial and program reports as well as overseeing the scope and accessibility of services. The DHS cannot delegate its duties and responsibilities to other state or local agencies, although DHS is specifically authorized to enter into cooperative arrangements with other state and local agencies to maximize the utilization and coordination of medical assistance within Rhode Island.
2. **Statewide service availability, adequacy, quality.** The DHS is required to ensure that Medicaid services are available statewide.
3. **Statewide access to efficient eligibility determination.** The DHS is required to provide all Rhode Island residents with the opportunity to apply for medical assistance, assure that eligibility will be appropriately determined, and make sure that the state will furnish medical assistance with reasonable promptness, in a manner consistent with simplicity of administration and the best interests of the recipients.
4. **Choice of and equitable access to service providers.** The DHS is required to assure that individual recipients have a choice of providers both within the fee-for-service and managed care components of the program, while at the same time assuring that methods and payment rates are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available to the Medicaid population in all geographic areas of the state.
5. **Sufficient availability of basic services, including the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.** The DHS is required to assure that services are of sufficient amount, duration and scope for both mandatory and optional services; and that EPSDT screenings and necessary medical services are available to Medicaid eligible persons under age 21.

Each state must determine how to administer the program across multiple agencies that have overlapping responsibilities and authorities to serve a variety of eligible populations. As indicated in (1) above, DHS may enter into cooperative agreements with other state agencies in order to maximize the utilization and coordination of services for the Medicaid population; however, DHS cannot delegate its duties or responsibilities.

Within these parameters and under Rhode Island state statutes, the Department of Human Services has shared stewardship for Rhode Island Medicaid with other agencies:

- Department of Mental Health, Retardation and Hospitals (MHRH)
- Department of Children, Youth and Families (DCYF)
- Department of Health (DOH)
- Department of Elderly Affairs (DEA)
- Local Education Agencies (LEAs) The relationships that constitute this shared stewardship are complex.

Exhibit 1 illustrates the services that are either purchased or provided by each state agency on behalf of the four Medicaid population subgroups.

Exhibit 2 illustrates the total FY 2005 state and federal expenditures for the Medicaid program by department.

EXHIBIT 1

Rhode Island Medicaid Purchased & Directly Provided Services by Department, FY 2005

Population	Department of Human Services	Department of Children, Youth and Families	Department of Mental Health, Retardation and Hospitals	Department of Elderly Affairs	Department of Health	Local Education Agencies
Adults with Disabilities	Basic MA services thru direct pay to FFS providers; Home & Community based services		Behavioral Health Services to Adults with Severe & Persistent Mental Illness; Substance Abuse Treatment; Certain Home & community based services Including Group Homes to adults with DD & MR; Slater Hospital	Assisted Living; Case management; Assistive Technologies	Targeted Case Management for People with AIDS State Laboratory	
Elderly Adults	Basic MA services thru direct pay to FFS providers Home & Community based services		Behavioral Health Services to Adults with Severe & Persistent Mental Illness; Substance Abuse Treatment; Certain Home & community based services Including Group Homes to adults with DD & MR; Slater Hospital	Home Health Services; Case management; Home delivered meals; Assisted Living; Assistive technology; minor home modifications, Senior companion program	State Laboratory	
Children and Families in Managed Care	Basic MA Service through Health Plans plus FFS for wrap around services; CEDARR Family services	Certain Behavioral Health Services	Substance abuse treatment		State Laboratory	Case Management & School - related Services; Individualized Education Plans (IEPs) for MA-eligible Special Education students
Children with Special Health Care Needs	Basic MA services thru Health Plans or direct pay to FFS providers; Comprehensive Evaluation, Diagnosis, Assessment, Referral and Re-evaluation (CEDARR) Family services;	Residential Placement; Certain Behavioral Health Services	Substance abuse treatment		State Laboratory	Case Management & School - related Services; Individualized Education Plans (IEPs) for MA-eligible Special Education students

ADMINISTRATION - CONTINUED

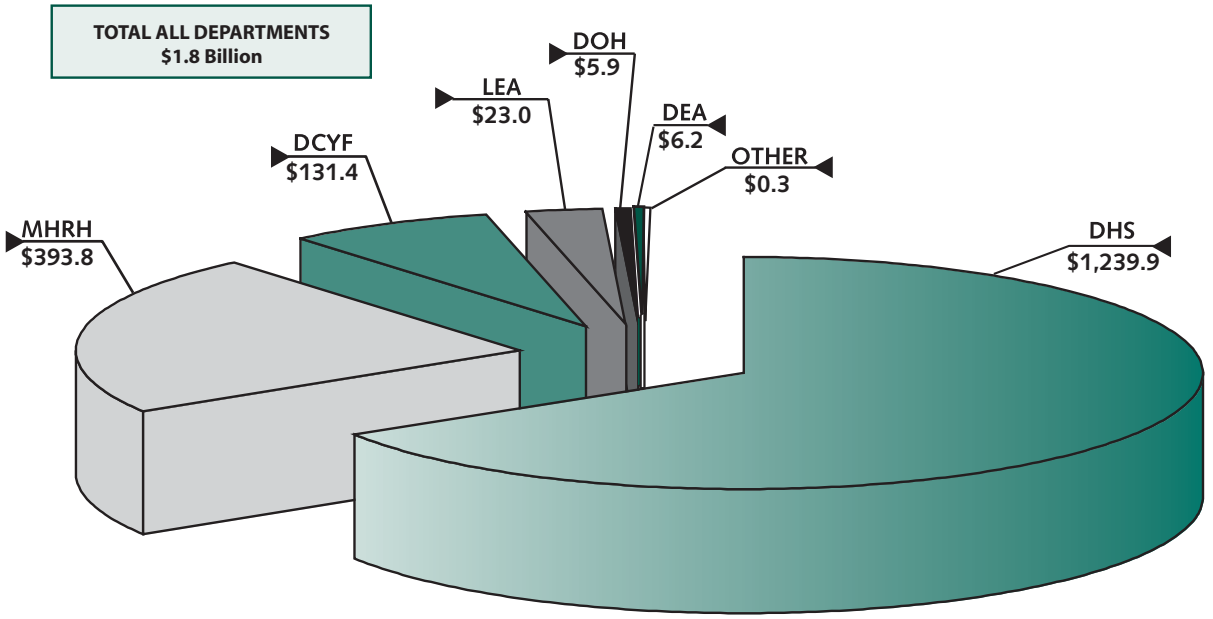
DHS is responsible for 68.8 percent of all Medicaid expenditures, MHRH is responsible for 21.9 percent, and DCYF is responsible for 7.3 percent. Combined, these three departments account for 98 percent of all RI Medicaid expenditures.

Exhibit 3 displays the eligibility pathways and the service delivery system options available to each subgroup. The population has been divided into these four categories based on similarities of service need and complexity, as related to age, family structure and disability.

Within DHS, the Division of Health Care Quality, Financing and Purchasing (the "Division") is responsible for administering the Rhode Island Medicaid program. The Division's program development, administration and staff are located in three centers:

- Center for Adult Health
- Center for Child and Family Health
- Center for Finance and Administration

EXHIBIT 2
RI Medicaid Total Expenditures by Department in Millions - FY 2005



DHS - Department of Human Services
MHRH - Department of Mental Health, Retardation and Hospitals
DCYF - Department of Children, Youth and Families
LEA - Local Education Agencies
DoH - Department of Health
DEA - Department of Elderly Affairs

EXHIBIT 3

Rhode Island Medicaid Eligibility Pathways and Delivery System Options (as of June 30, 2005)

Medicaid Population Subgroup	Eligibility Pathways	Delivery System Options
Children and families in managed care (Children under 19 and their parents)	• FIP/TANF • Section 1115(a) Waiver eligible • SCHIP • Certain poverty level children who are not eligible for TANF • 1931(e) Expansion parents	• Enrollment in a RIte Care Health Plan or Rite Share Premium Assistance Program plus limited FFS to fill in gaps in coverage • CEDARR
Children with special health care needs (as an eligibility factor) (Under age 22)	• Children who are – Blind and disabled SSI recipients – Katie Beckett eligible (eligible up to 18th birthday) – in Substitute care – in Subsidized adoption	• Traditional Fee-for-Service (FFS) • Enrollment in a RIte Care Health Plan plus limited FFS to fill in gaps in coverage • CEDARR
Adults with disabilities (Age 22-64)	• Blind and disabled SSI recipients • Medically needy • Blind & disabled persons at or below the poverty level • Long term care eligible	• Traditional FFS • Connect CARRE • Waiver programs – Developmental Disability (MHRH) – Aged and Disabled (DHS) – Habilitative (DHS) – Physically Disabled (DHS) – Assisted Living (DEA)
Aged (Age 65 and over)	• Aged, blind and disabled SSI recipients • Medically needy • Persons at or below the poverty level	• Traditional FFS • Waiver programs – Assisted Living (DEA) – Elderly (DEA) – Aged and Disabled (DHS) – Physically Disabled (DHS) – Developmental Disability (MHRH)

ADMINISTRATION - CONTINUED

The Division has been implementing its consumer-focused value-based purchasing philosophy by adopting the following operating principles to develop and manage its programs:

- Assess consumer needs.
- Involve consumers in the services they receive.
- Involve providers in defining performance expectations that respond to consumer needs and assure the quality and accountability of service provision.
- Define benefits, design payment methodologies and create contract structures that support:
  - -The improved health status of the consumer
  - - The ability to obtain and maintain work opportunities for those with disabilities
  - - The cost-conscious expenditure of public funds; and
  - - The use of data to track progress, inform decisions and continuously improve programs.

The Center for Adult Health (CAH) and the Center for Child and Family Health (CCFH) are responsible for program and policy development for the four Medicaid population subgroups. The activities of these two Centers are discussed in detail within the sections that follow.

In addition to administering programs for adults with disabilities and elderly adults, CAH oversees the Medicaid Management Information System (MMIS) on behalf of the Division. The MMIS processes medical claims, makes capitation payments, enrolls providers, maintains eligibility information and utilization reports. The Division is responsible for developing policies and procedures as well as monitoring the activities of its fiscal agent, Electronic Data Systems Corporation (EDS), as related to claims processing, provider relations and report generation.

As coordinator of the MMIS function, CAH has major responsibility for the implementation of and compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The intent of this federal legislation is to improve the availability and portability of health coverage through a variety of provisions. In addition, HIPAA, through its Administrative Simplification provision, requires the adoption of national standards for the electronic transfer of health care information including codes, identifiers, security and privacy. HIPAA requires that covered-entities, which include healthcare providers, insurers and healthcare claim billing clearinghouses, comply with published Federal rules or become subject to civil and criminal fines and sanctions. The RI Department of Human Services is the single-state agency responsible for ensuring that Medicaid operations, including those programs co-administered by several sister State agencies, become compliant with HIPAA regulations. Medicaid operations are widely dispersed within RI State government; therefore, a cohesive and coordinated effort has been necessary to ensure that all Federal mandates are implemented.

In addition to administering programs for children and families in managed care, children with special needs and children in foster care, CCFH oversees Research and Evaluation on behalf of the Division. The approach to Research and Evaluation originates from Medicaid's overarching goal, "to improve the health of the Medicaid population and, by so doing, improve the health of Rhode Island's population overall." Rhode Island Medicaid is working to ensure that programs measurably improve the health of the Medicaid population, and so need to be able to measure progress toward that goal. Research efforts assist programs by measuring and assessing progress. Information related to research and evaluation initiatives can be found on the RIte Care research web site at www.ritecareresearch.org.

ADMINISTRATION - CONTINUED

The Center for Finance and Administration (CFA) encompasses all the core administrative functions of the Medicaid program: budgeting; financial expenditure analysis; financial control of the MMIS; financial reporting; hospital-related service monitoring and payment; program integrity; recoveries from third parties for claims liability; estate recoveries; and calculation and distribution of the disproportionate share program (DSH) for uncompensated care in Rhode Island hospitals.

The CFA administers the Prospective Hospital Reimbursement Program as the Department of Administration's designee. This program has its origins in state law. In 1971, amendments were added to the enabling legislation for nonprofit hospital service corporations, i.e., Blue Cross of Rhode Island. These amendments mandated that hospital budget negotiations are necessary for the purpose of determining payment rates for hospitals.

The current participants in the program are the State of Rhode Island, the voluntary hospitals in the state and Blue Cross of Rhode Island. The major components of the program are: a negotiated statewide maximum ceiling on reimbursable expenses (MAXICAP); negotiated individual hospital operating budgets; and establishment of third-party payment rates for inpatient and outpatient services.

WHO IS ELIGIBLE?

All state Medicaid programs must cover the following people:

1. Recipients of Supplemental Security Income (SSI) or Supplemental Security Disability Insurance (SSDI)[1];
2. Low income Medicare beneficiaries.
3. Individuals who would qualify for Aid to Families with Dependent Children Program (AFDC) today under the state's 1996 AFDC eligibility requirements [2];
4. Children under age six and pregnant women with family income at or below 133 percent of federal poverty guidelines;
5. Children born after September 30, 1983, who are at least age five and live in families with income up to the federal poverty level;
6. Infants born to Medicaid-enrolled pregnant women;
7. Children who receive adoption assistance or who live in foster care, under a federally-sponsored Title IV-E program;

In addition, Rhode Island Medicaid has chosen to cover these optional groups:

1. Low-income elderly adults or adults with disabilities;
2. Individuals eligible for Home and Community Based Services Waiver programs.
3. Children and pregnant women up to 250 percent and parents up to 185 percent of the federal poverty level, including children funded through the State Children's Health Insurance Program (SCHIP);
4. Individuals determined to be "medically needy" due to low income and resources or to large medical expenses;
5. Children under 18 with a disabling condition severe enough to require institutional care, but who live at home (the "Katie Beckett" provision);
6. Women eligible for the breast and cervical cancer program.

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1 SSI is a federal income assistance program for disabled, blind or aged individuals that is independent of individuals' employment status. SSDI is an insurance program for those who have worked a specified amount of time and have lost their source of income due to a physical or mental impairment.

2 Federal policymakers severed the tie between medical and cash assistance when the AFDC program was replaced in 1996. The AFDC standard was retained in Title XIX to prevent the states from using the more restrictive eligibility requirements and time limits of AFDC's successor - Temporary Assistance for Needy Families or TANF - when providing Medicaid coverage to needy children and families.

WHO IS ELIGIBLE? - CONTINUED

Within DHS, the Division of Health Care Quality, Financing and Purchasing administers the Rhode Island Medicaid program. The program manages services for four population subgroups across two Centers:

The Center for Adult Health manages:

- Adults with disabilities;
- Elderly adults; and
- Women with breast and cervical cancer

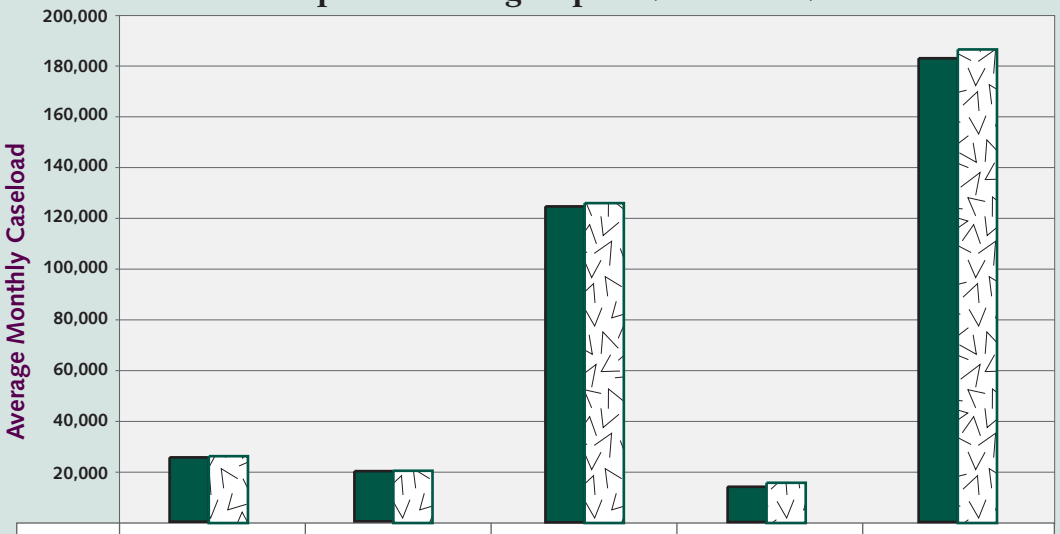
The Center for Child & Family Health manages:

- Children and families in managed care including:
  - RIte Care
  - RIte Share
- Children with special health care needs,
  - Children eligible due to SSI or the Katie Beckett provision
  - Children in Subsidized Adoption
  - Children in Subsititute Care (Foster Care)

Exhibit 4 displays the average monthly caseload[3] of Medicaid recipients by subgroup for fiscal year 2005. The total of 185,899 recipients are distributed as follows:

- 25,820 adults with disabilities
- 19,784 elderly adults
- 125,060 children and families in managed care (includes 5,796 RIte Share enrollees)
- 15,235 children with special health care needs

EXHIBIT 4
Rhode Island Medicaid Average Monthly Caseload by Population Subgroup FY2004 & FY2005



Subgroup	Adults with Disabilities	Elderly	Children & Families in Managed Care*	Children with Special Health Care Needs	TOTAL
FY 2004	25,330	19,665	123,761	13,869	182,625
FY 2005	25,820	19,784	125,060	15,235	185,899

*includes RIte Share

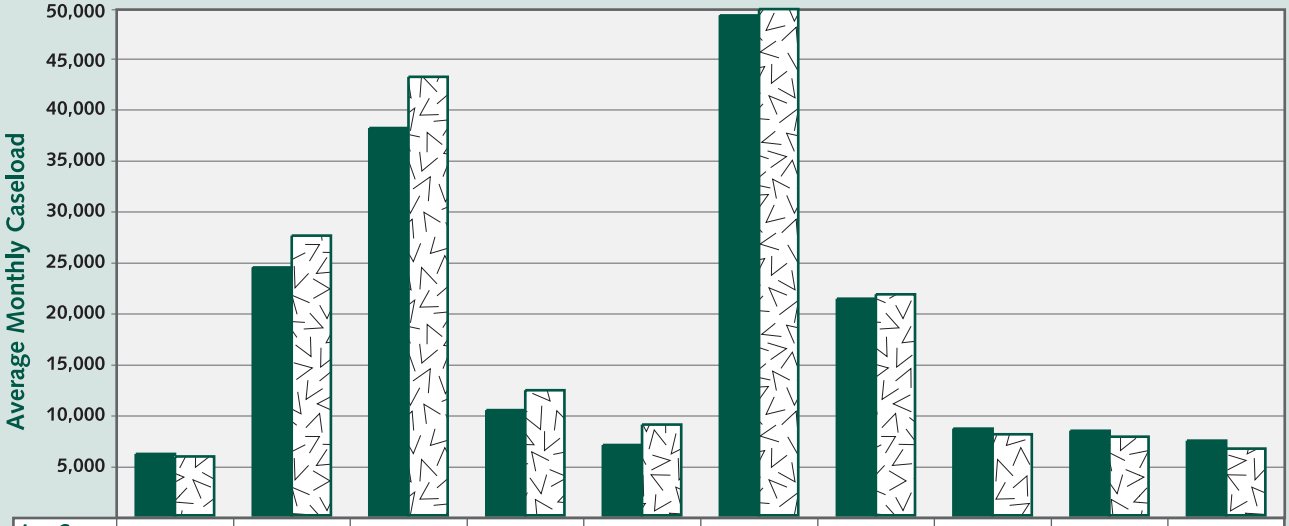
3. The average monthly caseload of Medicaid recipients represents the number of individuals enrolled in a given month regardless of the length of time they were eligible (from 1 to 31 days). The average monthly caseload for the year is calculated by averaging the monthly caseload for 12 months. The unduplicated count of Medicaid recipients represents the number of unique individuals enrolled during the year regardless of the length of time they were eligible (from 1 to 365 days). The unduplicated count is higher than average monthly caseload. Average monthly caseload is used in most budgeting and financial calculations and in the caseload estimating conferences

WHO IS ELIGIBLE? - CONTINUED

Exhibit 5 displays the FY 2005 Medicaid population by age group.

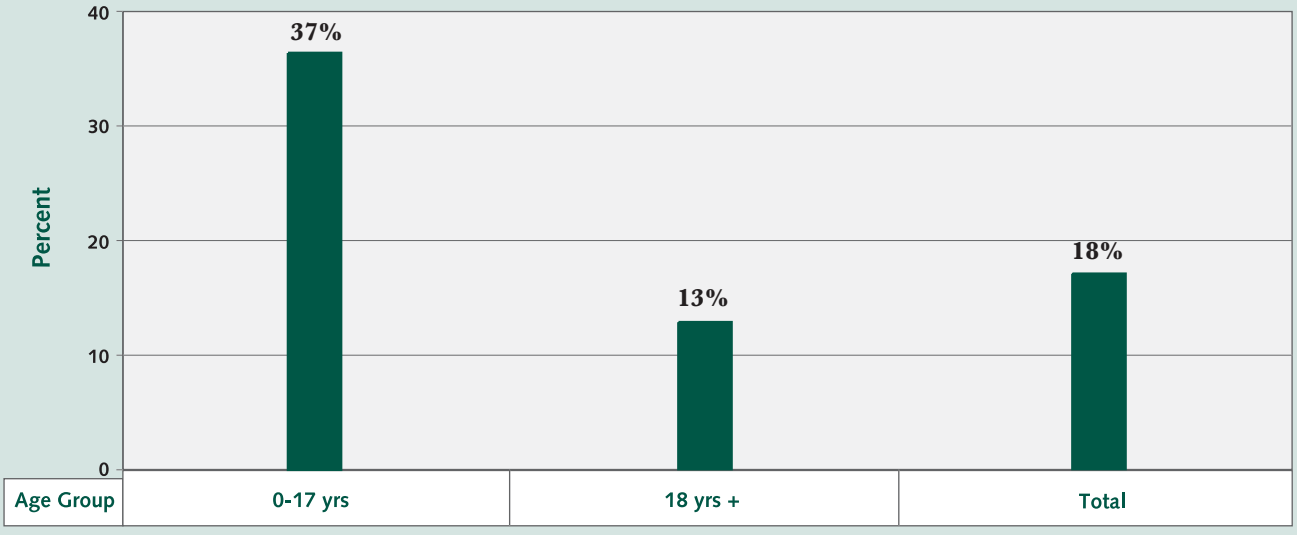
Exhibit 6 displays the Medicaid population as a percent of the Rhode Island populations of children and of adults. Overall, Medicaid recipients made up 18 percent of the state population. Medicaid covered an estimated 37 percent of all Rhode Island children under age 18 years and 13 percent of persons 18 years and older during 2005.

EXHIBIT 5
Rhode Island Medicaid Average Monthly Caseload by Age Group FY 2004 & FY 2005



Age Group	0-1 yrs	1-5 yrs	6-14 yrs	15-17 yrs	18-21 yrs	22-44 yrs	45-64 yrs	65-74 yrs	75-84 yrs	85 yrs +
FY 2004	6,103	24,092	38,042	10,209	6,685	49,454	21,352	8,259	8,401	7,290
FY 2005	6,093	27,601	44,285	13,364	8,893	50,231	21,938	8,056	8,351	6,852

EXHIBIT 6
Rhode Island Medicaid Average Monthly Caseload as a Percent of Rhode Island Population FY 2005



Sources: US Census 2000
RI Medicaid Program Data

WHAT SERVICES ARE COVERED?

Exhibit 7 lists the services covered by Rhode Island Medicaid. All recipients are eligible to receive "Basic Medicaid Services" unless otherwise specified. Please note that:

- To be eligible as medically needy, a recipient must have income and resources below specified limits, or have large medical expenses;
- To be eligible for Waiver services, recipients must meet specific criteria. (For information on Waiver programs, please see the DHS web site at www.dhs.ri.gov)
- To be eligible to participate in federal Medicare buy-in, a recipient must meet Medicare requirements and have income and resources below specified limits.

EXHIBIT 7
Rhode Island Medicaid State Plan Services
FY 2005

Basic Medicaid Services — Mandatory State Plan Services plus Optional State Plan Services offered in RI, i.e.:

Mandatory State Plan Services

States are required to offer coverage to the categorically needy for these services:

- Inpatient hospital services
- Outpatient hospital services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and x-ray services
- Nursing facility services for individuals 21 and older
- Early & periodic screening, diagnostic and treatment services (EPSDT) for individuals under age 21
- Family Planning services
- Physicians' services
- Home health services for any individual entitled to nursing facility care
- Nurse-midwife services to the extent permitted by State law
- Services of certified nurse practitioners and certified family nurse practitioners to the extent they are authorized to practice under State law

Optional State Plan Services offered in RI

- Podiatrists services
- Optometrists services
- Dental services
- Prescribed drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Diagnostic services
- Preventive services
- Rehabilitative services
- Services in an IMD for individuals age 65 and over
- Inpatient psychiatric services for individuals under age 21
- NF services for individuals under age 21
- Personal care services
- Adult Day Services
- Incontinent Supplies
- Transportation services
- Case management services
- Hospice services
- TB services for certain TB infected individuals

Medically Needy State Plan Services — prenatal & delivery for pregnant women, ambulatory services for individuals under 18 and those entitled to institutional care, home health services for individuals entitled to nursing facility services, mandatory state plan services for over 65 & under 21 in an IMD or ICF/MR.

Waiver Services — Home or community based services not otherwise furnished under the State's Medicaid plan and have been approved under a waiver request to CMS. These consist of any or all of the following: case management services, homemaker services, personal care services, adult day health services, habilitation services, respite services, minor assistive devices, minor modifications to the home, and other medical or social services as requested by the state and found to be cost-effective to prevent institutionalization.

Federal Medicare Buy-in — Direct payment or annual stipend to pay Medicare deductibles, co- payments and coinsurance, only.

Employer Sponsored Health Insurance (ESI) Premium Assistance — If cost-effective, the state pays the employees share of ESI premium if Medicaid eligible has access to ESI.

Enrollee Co-premium — Under managed care programs for children and familes, enrollees must pay a sliding scale co-premium based on family income.

HOW IS MEDICAID FINANCED?

Exhibit 8 displays Rhode Island's FMAP rate from 2001 through 2007 for Title XIX (Medicaid) and Title XXI (State Children's Health Insurance Program (SCHIP)[4] expenditures. Medicaid enrollment is not limited based on a pre-set expenditure cap. By federal law, eligible individuals cannot be denied enrollment or covered services based on insufficient government funds. Since 2003 & 2004, when states were given a one-time increase in FMAP, Rhode Island's FMAP rate has been declining. For each percentage point decline in FMAP, approximately $1.8 million of expenditures shift to the state of RI.

Exhibit 9 shows total combined federal and state expenditures for Rhode Island Medicaid in FY 2005. Total expenditures for benefits and administration were $1.8 billion. Medicaid expenditures constitute a sizable proportion of the total state budget. In fiscal year 2005, Medicaid accounted for 28 percent of the state budget (all funds).

HOW ARE MEDICAID DOLLARS USED?

Exhibit 10 displays Medicaid expenditures by population group. Total program expenditures grew seven percent between fiscal years 2004 and 2005. The largest absolute increase, i.e., $42 million occurred in the adults with disabilities subgroup. The largest percentage increase, i.e., ten percent, occurred in childrenwith special health care needs.

4 Through SCHIP, the federal government provides states with an "enhanced" FMAP rate to encourage enrollment of children in the program.

EXHIBIT 8
RI Medicaid State & Federal Matching Rates 2001 to 2007

MEDICAID TITLE XIX

Federal FY	State %	Federal %
2001	46.21%	53.79%
2002	47.55%	52.45%
2003*	43.13%	56.87%
2004*	41.76%	58.24%
2005	44.62%	55.38%
2006	45.55%	54.45%
2007	47.65%	52.35%

SCHIP TITLE XXI

Federal FY	State %	Federal %
2001	32.35%	67.65%
2002	33.28%	66.72%
2003	31.22%	68.78%
2004	30.78%	69.22%
2005	31.23%	68.77%
2006	31.88%	68.12%
2007	33.35%	66.65%

Source: Center for Medicare and Medicaid Services

* under PL. 108-27, the Jobs and Growth Reconciliation Act, the federal match was increased by 2.95 point so that from April 2003 to September 2003 the FMAP was 58.35% and from October 2003 to June 2004 the FMAP was 59.98%.

EXHIBIT 9
Rhode Island Medicaid Total Expenditures FY 2005

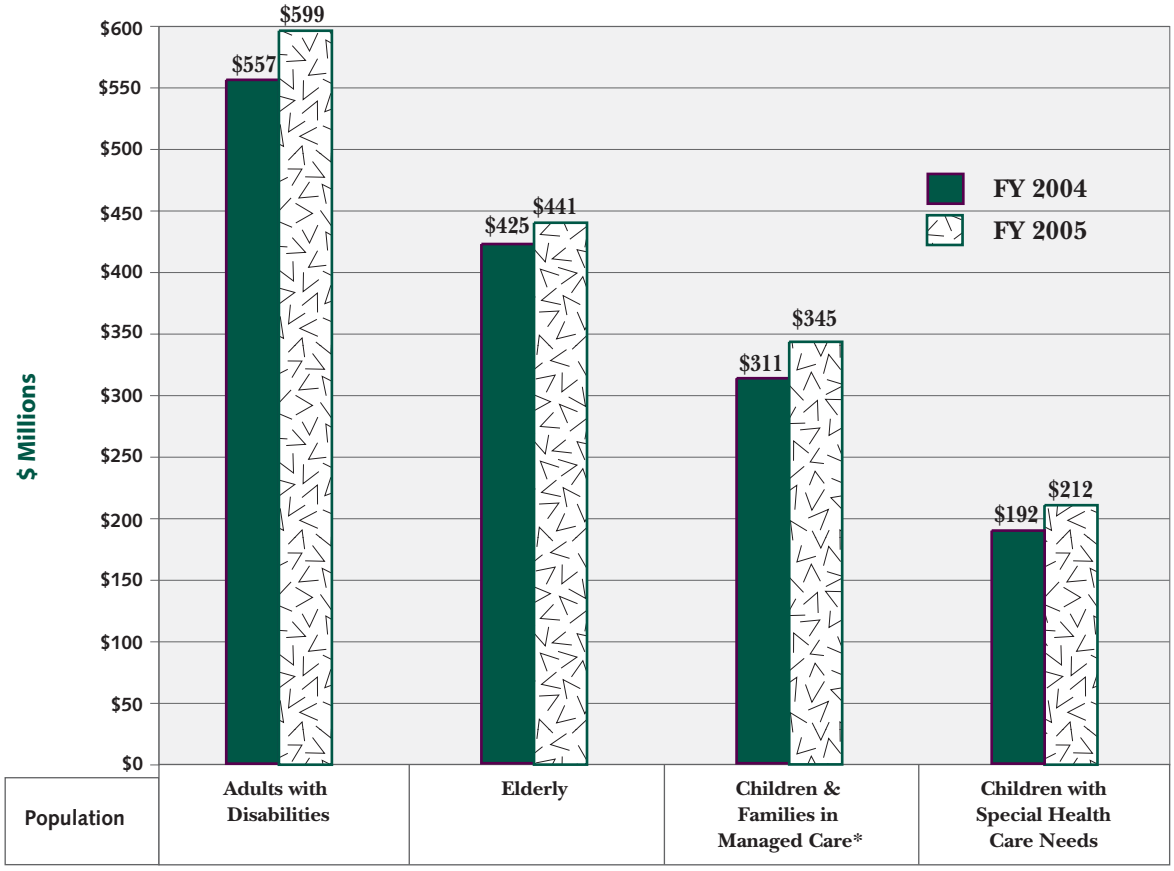
Line Items/ Departments	Expenditures	Percent
Hospital - Regular	$ 135,513,759	7.5%
Hospital - Disproportionate Share payments	$ 108,731,155	6.0%
Nursing Homes	$ 292,757,265	16.3%
Managed Care	$ 378,267,536	21.0%
Other	$ 273,414,984	15.2%
Restricted Receipt	$ 5,437	0.0%
Administration-DHS	$ 51,255,088	2.8%
Total DHS	$1,239,945,224	68.8%
Total MHRH	$ 393,802,580	21.9%
Total DCYF	$ 131,379,226	7.3%
Total LEA*	$ 23,504,834	1.3%
Total DOH	$ 5,919,061	0.3%
Total DEA	$ 6,249,674	0.3%
Total Other	$ 311,919	0.0%
TOTAL ALL DEPARTMENTS	**$1,801,112,518**	**100.0%**

DHS: RI Department of Human Services
MHRH: RI Department of Mental Health, Retardation and Hospitals
DCYF: RI Department of Children, Youth and Families
LEA: Local Education Authorities
DOH: RI Department of Health
DEA: RI Department of Elderly Affairs

* decrease in Lea results from a state auditor opinion regarding imputed state share

EXHIBIT 10

Rhode Island Medicaid Program Expenditures by Population Subgroup - FY 2004 and FY 2005 ($ in Millions)



* includes RIte Share

HOW ARE MEDICAID DOLLARS USED?-CONTINUED

Exhibit 11 compares the caseload distribution for each subgroup with the associated distribution of expenditures. While children and families in managed care represent 67 percent of the total caseload, they account for only 22 percent of program expenditures. Conversely, adults with disabilities and the aged combined rep-resent 25 percent of the total caseload but account for 66 percent of all expenditures. In addition, children with special health care needs represent 8 percent of total caseload and account for 13 percent of all expenditures.

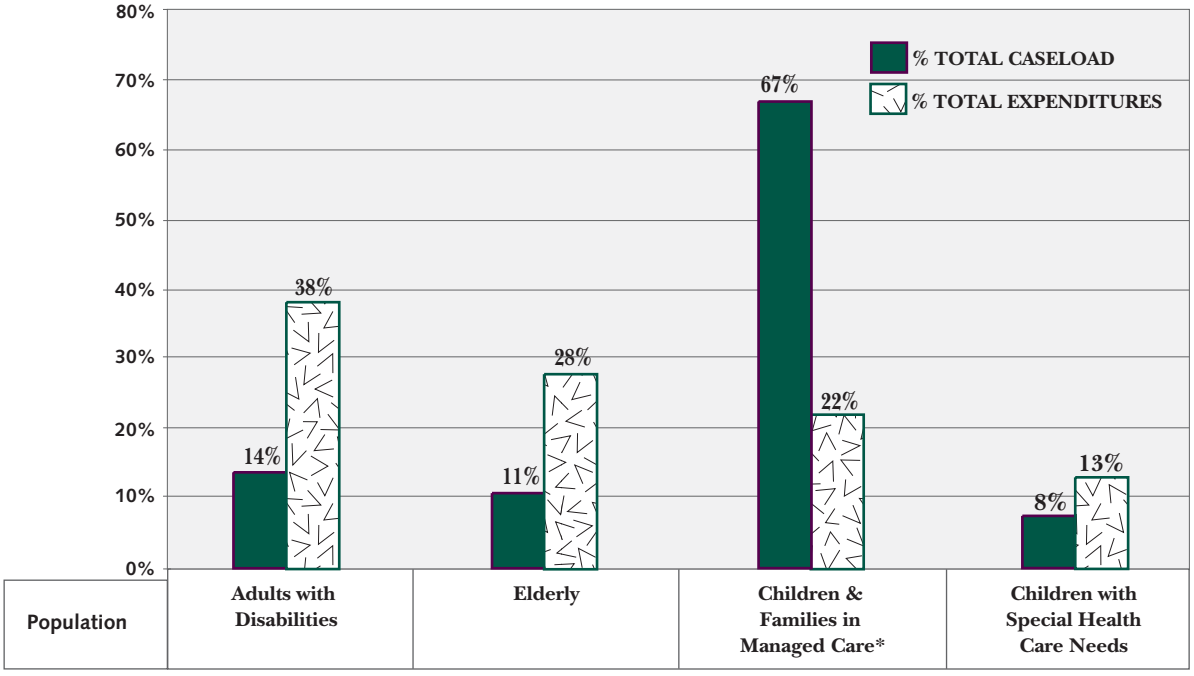
Exhibit 12 displays medical expenditures by category of service provider, ranked by expenditure volume:

- $415 million for home and community based services
- $392 million for institutional service providers (nursing homes and Eleanor Slater Hospital)
- $333 million for acute-care hospitals
- $228 million for pharmaceuticals
- $147 million for providers of behavioral health services
- $83 million for physicians and other professional services

The decrease in expenditures for physicians and other professional services resulted from a reclassification of laboratory and radiology claims by the RIte Care health plans from other professional services to outpatient hospital services.

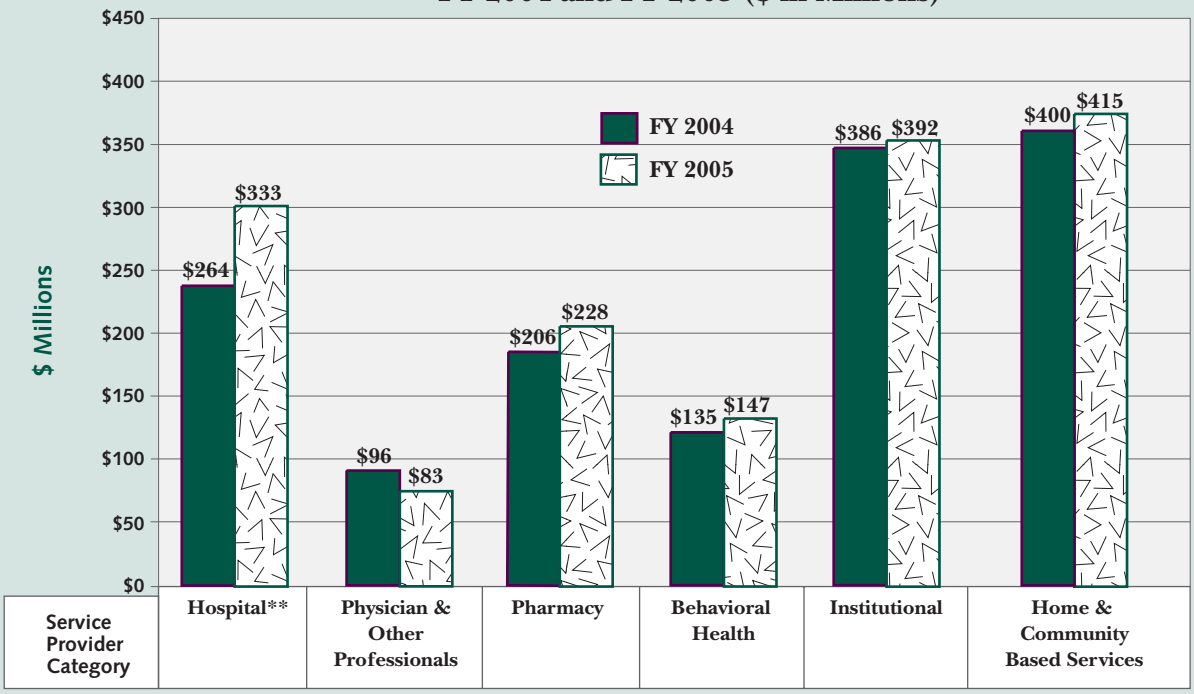
Average per capita per month (PCPM) costs are shown in **Exhibit 13**. The per capita spending on children and families in managed care is significantly lower than the PCPM for other populations. In 2005, the PCPM for the elderly increased the most, i.e., $62 PCPM, over the previous year. The PCPM for the adults with disablites increased $35 PCPM over FY 2004. The PCPM for children with special health care needs increased $37 PCPM and children and families increased $21 PCPM.

EXHIBIT 11
Rhode Island Medicaid Percent Program Expenditures vs Percent Caseload by Population Subgroup - FY 2005



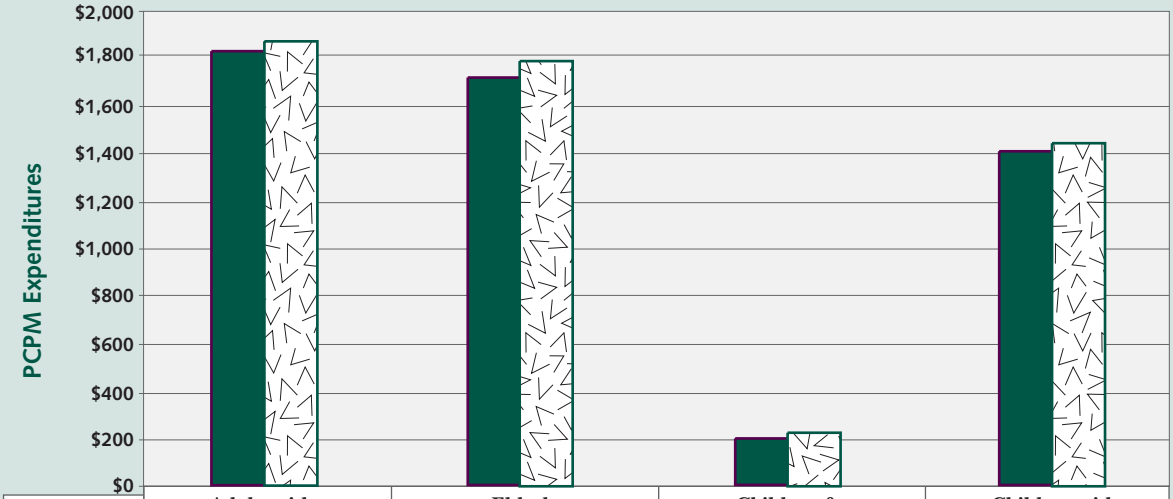
* includes RIte Share

EXHIBIT 12
Rhode Island Medicaid Program Expenditures* by Service Provider Category FY 2004 and FY 2005 ($ in Millions)



*excludes RIte Share
**excludes disproportionate share payments

EXHIBIT 13
Rhode Island Medicaid Per Capita Per Month (PCPM) Program Expenditures – FY 2004 and FY 2005



Population	Adults with Disabilities	Elderly	Children & Families in Managed Care*	Children with Special Health Care Needs
FY 2004	$1,834	$1,725	$206	$1,409
FY 2005	$1,869	$1,787	$227	$1,446

*excludes RIte Share

CENTER FOR ADULT HEALTH

PROGRAMS & INITIATIVES

WAIVER PROGRAMS

Most of the adults with disabilities and elderly adults enrolled in Medicaid receive services through the traditional Medicaid program. In addition, individuals who meet an institutional level of care may participate in one of Rhode Island's six home and community based services (HCBS) waiver programs. Waiver program participants receive home and community based services along with the full range of traditional Medicaid services. Under Federal rules, waiver programs must demonstrate that the following five assurances are met: 1) health and welfare of participants, 2) financial accountability, 3) evaluation of participant needs, 4) participant choice of service providers and settings of care, and 5) cost neutrality as compared to the institutional alternative.

The Department of Human Services (DHS) administers the **Aged and Disabled Waiver program**. Enrolled individuals are eligible for case management, personal care, environmental modifications, special medical equipment, Meals-on-Wheels, senior companion and emergency response services. The waiver was initiated in 1983 and is approved through 2008. In fiscal year 2005, 1,747 individuals received services through the Aged and Disabled waiver program.

The **Physically Disabled Waiver** is administered through a partnership between DHS and the People Actively Reaching Independence (PARI) Independent Living Center. Independent living agencies provide case management and personal care services for individuals with quadriparesis or functional hemiparesis. Participants may receive case management, a personal care attendant, consumer preparation, environmental modifications, special medical equipment, homemaker services and emergency response services. Eighty-eight individuals received services through this waiver in FY 2005. The waiver began in 1988 and will be phased out and replaced by the new PersonalChoice Program in 2006.

The **Assisted Living Waiver** is a collaborative effort of DHS and the Department of Elderly Affairs and provides services to individuals residing in certain assisted living facilities. The waiver funds case management, assisted living and special medical equipment for eligible individuals. The waiver began in 1999 and is approved through 2007. This waiver served 288 people in FY 2005. The Assisted Living Waiver was reviewed by the Centers for Medicare and Medicaid Services (CMS) in 2005, and found to be in compliance with Federal waiver requirements.

The DHS and the Department of Mental Health, Retardation and Hospitals (MHRH) administer the **Mentally Retarded, Developmentally Disabled Waiver.** Services funded under this waiver include case management, specialized homemaker, adult foster care, homemaker, respite, environmental modifications, special medical equipment, residential habilitation, day habilitation and supported employment. In FY 2005, 2,780 persons received waiver services. This waiver program was initiated in 1983 and is approved through 2006. This waiver was also federally reviewed in 2005, and found to be in compliance with waiver regulations.

The DHS and Department of Elderly Affairs (DEA) administer the **Community Based Elderly Waiver**. Eligible individuals must be over age 65, and can receive case management, homemaker, personal care, Meals-on-Wheels, senior companion, environmental modifications and special medical equipment. In FY 2005, 690 Rhode Islanders received services under this waiver. The waiver began in 1988 and is approved into 2006. The DEA waiver was evaluated by CMS in 2005, and also found to be in compliance with federal requirements.

The **Habilitation Waiver** is administered through a partnership between the Department of Human Services (DHS) and the People Actively Reaching Independence (PARI) Independent Living Center. The independent living agency provides case management and works with MHRH certified providers and licensed home health agencies to arrange for needed residential and day habilitation services, private duty nursing, personal care, supported employment, special medical equipment, minor home modifications, personal emergency response units and community-based rehabilitation services. The Waiver began in 2001 and is approved through 2009. Twenty-five people received these Waiver services in FY 2005.

ADULT HEALTH PROGRAMS & INITIATIVES - CONTINUED

CASH AND COUNSELING (PERSONAL CHOICE) PROGRAM

Utilizing a $250,000 Robert Wood Johnson Foundation grant awarded to DHS in 2004, the Department continues work to implement a Cash and Counseling program (in Rhode Island it will be called PersonalChoice). This program is designed to allow adults with disabilities and elders who are Medicaid eligible and require some assistance with their personal care to exercise greater control in the provision of that assistance. Rhode Island is one of 14 states nationally that is building on the success of the Cash and Counseling Demonstration Project that took place in three states (New Jersey, Florida and Arkansas).

Unique features of this program include; the ability of the service recipients to control a monthly budget, based on their self-care needs, that can be used to hire personal care assistance, housekeeping and chore services; the ability to have greater control over the time, place and manner in which the services are provided; and have greater flexibility and choice in how their Medicaid benefits are allocated.

DHS will be contracting with existing community agencies to provide assistance to participants to: develop and monitor their individual plans of care; manage their budgets; assess their needs for home modifications and adapted equipment, and assess their health maintenance and wellness needs. All services are designed to improve the personal independence and community inclusion of the participant.

Enrollment of participants will commence in February of 2006 when participants in the Physically Disabled (PARI) Waiver are transitioned onto this program as well as other eligible adults with disabilities and elders.

BRAIN INJURY IMPLEMENTATION GRANT

In March 2002, the US Department of Health and Human Services, Health Resources and Services Administration (HRSA) awarded a three-year, $600,000 Traumatic Brain Injury (TBI) Implementation Grant to the DHS Center for Adult Health that was subsequently extended to March 2006. The successful completion of the Rhode Island Plan for TBI Services under the DHS 2000 HRSA TBI Planning Grant led to this proposal and subsequent award.

Highlights of the project for FY 2005 include:

- Completion of Brain Injury 101, Case Management, and Vocational Rehabilitation Training videos for service providers
- Update of a statewide Resource Guide that includes brain injury specific and general disability/elder/child resources, disseminated to over 3,000 people statewide
- Over 9,000 additional multi-language fact sheets and concussion cards were distributed statewide
- Annual conference for survivors, families and professionals in March 2005 had over 200 participants
- Multiple educational presentations and media broadcasts were conducted statewide, and
- More than a 200% increase in telephone inquiries to the Brain Injury Resource Center

The Brain Injury Association of Rhode Island is under contract with the DHS Center for Adult Health to conduct grant activities. A new proposal for a three year TBI grant was submitted in November 2005, with notification of award expected in February 2006.

SYSTEMS CHANGE GRANTS FOR COMMUNITY LIVING

Real Choice Systems Change Grant

Fiscal Year 2005 was an active year for this grant. A full time contract consultant was hired to coordinate the Real Choices Grant and the Nursing Facility Transitions Grant activities. A work group was convened to develop an RFP for a web-based Human Service Resource Directory and Benefits screener. Department staff are working in conjunction with staff from other state agencies on grant activities. Specifically, with the Department of Elderly Affairs (DEA), service-tracking software was purchased and staff training on the software provided. The Department of Children Youth & Families is continuing an analysis of community-based behavioral health care services for kids that will guide DHS in identifying priority areas and planning to meet those priorities.

The URI College of Pharmacy began a data analysis of potentially dual eligible (Medicaid/Medicare) beneficiaries. Staff from the New England States Consortium Systems Organization developed a needs assessment survey that was piloted to residents in assisted living facilities.

A work group was convened to plan the state's first community living conference 'Community Options for All' held in September 2005. This two-day event provided seniors and individuals with disabilities with information on current trends in community living and the wide spectrum of community-based services available in RI. The CAH Consumer Advisory Committee continued to meet quarterly to provide feedback on these grant activities.

Nursing Facility Transitions Grant

Several activities were undertaken to support the grant's goals to provide individuals residing in nursing facilities with information on community service options, help interested persons transition to a community living arrangement with necessary supports, and enhance the capacity of the home and community based system to serve individuals with multiple and/or complex needs. Two in-service trainings involving 90 discharge planners were held in conjunction with DEA. The grant coordinator collaborates with staff in the Office of Medical Review to identify individuals who may require assistance with transition.

In FY 2005, there were 34 new referrals to the program and 21 persons actually discharged from institutional settings. The program purchased furniture, household items, apartment security deposit, daily living equipment (such as grab bars), and safety equipment (such as a remote control deadbolt to prevent an individual with a Brain Injury from wandering), and items to improve home accessibility (such as offset hinges).

A work group was convened to evaluate the proposals submitted through the RFP process for the Adult Day Habilitation program for individuals with severe cognitive disability. This project was awarded in September 2005 to Generations Adult Day Care.

Respite Planning for Adults

The Center for Adult Health was awarded another Real Choices grant in October 2003 to evaluate Rhode Island Respite Services for adults. To date, the evaluation process has included a detailed research review and state benefit comparison, and a series of stakeholder meetings and focus groups. The evaluation will be complete by October 2006.

ADULT HEALTH PROGRAMS & INITIATIVES - CONTINUED

PACE PROGRAM

PACE (Program for All-Inclusive Care for the Elderly) Programs coordinate and provide comprehensive, primary, specialty, and preventative medical care, as well as community support and social services enabling older individuals to continue residing in the community. PACE is an innovative model that enables individuals who are 55 years or older and certified to need nursing home care to live as independently as possible. The PACE program integrates both service delivery and reimbursement.

Over the last year the Department of Human Services in collaboration with the Department of Elderly Affairs and the University of Rhode Island has been working with CareLink, a non profit management service organization, to establish a PACE Program in Rhode Island. These efforts have resulted in CareLink establishing the PACE Organization of Rhode Island, a non-profit entity that will manage and operate a PACE site. A formal application was submitted to and approved by the Centers for Medicare and Medicaid Services to establish the PACE Organization of Rhode Island as Rhode Island's first PACE provider. The PACE Program began enrolling beneficiaries on December 1, 2005.

MEDICARE PART D IMPLEMENTATION

The Federal Government passed legislation in 2004 to create a new Medicare pharmacy program known as Medicare Part D. As a result of this legislation, all beneficiaries who have both Medicare and Medicaid coverage must begin receiving Medicare covered pharmaceuticals from a Medicare Part D plan as of January 1, 2006, instead of from Medicaid. In addition, the state must begin to pay the federal Centers for Medicare and Medicaid Services (CMS) for the costs CMS determines would have been incurred by the state for this pharmaceutical coverage.

The Center for Adult Health instituted required changes in federal reporting methods and MMIS changes for new billing processes and edits. It also has been engaged in a multi-tiered member services strategy to ensure Medicaid beneficiaries become enrolled and understand the program. This strategy included mailings and a contract for additional personnel to staff the "Point" telephone information service. Member services have been closely coordinated with all agencies under the Executive Office of Health and Human Services, especially the Department of Elderly Affairs.

WORKING ADULTS WITH DISABILITIES BUY-IN

The Rhode Island General Assembly passed the Sherlock Act in 2004, directing the Department of Human Services to institute a program in which working adults with disabilities can pay a premium in order to gain full Medicaid coverage. Key benefits of this program are:

- The most liberal eligibility standards of any for single adults needing Medicaid
- Provides incentive for paid employment (premiums are much lower on paid employment)
- Eliminates Medicaid "flex" for those who work
- Those losing this eligibility can still keep retirement and medical savings accounts without effect on Medicaid eligibility

ADULT HEALTH PROGRAMS & INITIATIVES - CONTINUED

LONG TERM CARE INITIATIVE

State policy makers have long expressed concern about the escalating cost of and increasing demand for high-quality long-term care services for elderly individuals and those with chronic disabilities. Recently, financial pressures, workforce shortages, nursing home quality concerns and the state's aging population, among other issues, have heightened concern about the capacity and fiscal viability of the state's long term care system.

The Rhode Island General Assembly passed a joint resolution in 2005 requesting that the Department of Human Services engage appropriate consultant services to provide an analysis of the following:

- Determine the full scope of need for long-term care services in Rhode Island to include:
- Home Care
- Adult Day Care
- Respite Services
- Assisted Living
- Nursing Facility Care
- Review and recommend appropriate financing structures that will ensure access to services for those in need of community-based long-term care

To date, the DHS engaged the New England States Systems Consortium to conduct a benchmarking survey of the New England states on reimbursement rates and methodologies for community-based long-term care services. A Long Term Care System Assessment Work Group has met three times, and consultant services from the University of Maryland were secured to complete the analysis and report. The findings and recommendations will be delivered to the Joint Legislative Committee on Health Care Oversight in early 2006.

BREAST & CERVICAL CANCER PROGRAM

Taking advantage of a federal coverage option, the Department of Human Services and Department of Health in concert with representatives of women's cancer organizations designed and implemented a program to allow women with breast or cervical cancer or pre-cancerous symptoms to gain Medicaid eligibility. To be eligible a woman must be screened by the DOH-administered Women's Cancer Screening Program. The screening program is funded by the Federal Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program. The screening program provides no-cost pelvic exams, Pap tests, clinical breast exams, and mammograms to uninsured, low-income women.

Any woman screened by a provider who participates in the program and is found to have cancer or pre-cancerous symptoms can enroll in Medicaid for the duration of her treatment. Although eligibility for coverage is based on the woman's need for cancer-related treatment, enrolled women are eligible to receive the full scope of Medicaid services.

Coverage was provided to 98 new participants during fiscal year 2005. Of the total, thirty-eight (38) had either breast or cervical cancer and sixty (60) were eligible due to a pre-cancerous condition. A woman is eligible for coverage under this program until one of the following occurs: her course of treatment for breast or cervical cancer ends; she turns 65; she gains creditable coverage; she fails to complete a scheduled redetermination; or she is no longer a Rhode Island resident. Since its inception in April 2001, six hundred (600) women have benefited from this program.

ADULT HEALTH PROGRAMS & INITIATIVES - CONTINUED

CHRONIC CARE PROGRAMS

Connect CARRE

The Connect CARRE Program is a Care Management and Wellness Program developed by the Rhode Island Department of Human Services, Center for Adult Health, and the Neighborhood Health Plan of Rhode Island. It was designed to bring quality, coordinated care to some of the state's most compromised and challenged consumers. The enrolled individuals, fee-for-service adults age 22 years and older, are often socially isolated, with multiple chronic medical conditions including mental illness. This culturally diverse and economically disadvantaged group presents unique challenges for the Nurse Care Managers of Connect CARRE. The program has recruited and enrolled over 500 individuals over the past three years, and currently has 230 active enrollees. Provider and member satisfaction, specific disease management health care indicators and clinical outcomes are key measures of program success. In addition, the program has experienced a decline in unnecessary hospitalizations, improved access to providers, services and care in the community, and most importantly improved quality of life for participants.

The Connect CARRE Program was initiated in 2002. The Program partnered with Neighborhood Health Plan of Rhode Island to provide Nurse Case Managers and an interdisciplinary team of professionals to improve the health care status and outcomes for high-risk individuals with chronic disease states and conditions. This comprehensive program relies on the Nurse Case Manager to assist consumers in linking to a medical home, developing consistent relationships with their health care providers, managing chronic illness and coordinating services in the community in order to maintain wellness. The Nurse Case Manager also collaborates with the primary care physician and the consumer to provide chronic care and prevention focused visits. The program includes disease management principles and shared information to support lead physicians in their effort to maintain wellness for their patients with a chronic disease.

The Connect CARRE Program was developed in response to concerns about the cost and quality of care for the fee-for-service Medicaid adults with disabilities and elders. The goals for the Connect CARRE Program are to implement a care management program for approximately 300 adult Medicaid consumers, improve wellness of chronically ill consumers by utilizing a unique approach of engaging, educating and empowering individuals to self manage and self advocate through a series of nurse case management interventions and approaches, appropriately shift care from the most costly inpatient setting to the community and ambulatory setting, increase access to behavioral health services, and improve disease specific medication compliance.

The implementation of this program resulted in numerous barriers and challenges. The initial challenge was to identify an appropriate target population with high utilization of acute services and specific chronic diseases through Medicaid claims data. This required the creation of a predictive modeling search capacity that could identify Medicaid recipients who had high utilization of acute inpatient and ED services for the specific chronic diseases, lived in the community, and were currently active Medicaid recipients. The second challenge was recruiting physicians to participate in the program. It was difficult to identify, engage and communicate with Primary Care Physicians. The Connect CARRE Program was modified to create physician recruiting strategies that included additional payment for care planning conferences, practice supports for managing difficult and time consuming patients, and improved communication with other providers.

The two greatest program challenges were recruiting individual consumers into this voluntary program with minimal staff and resources, and encouraging them to participate. After months of recruiting through provider and community outreach and letters of invitation to targeted individuals, the program was again modified to include an "OPT OUT" strategy where

individuals who met program enrollment criteria were notified that they were being enrolled, and could opt out if they chose. This strategy did increase enrollment, but with inaccurate addresses and limited consumer response, it was not enough to keep the program viable. The final and most successful recruiting strategy has been the creation of an onsite Nurse Case Manager at Rhode Island Hospital as part of a Medicaid quality improvement project. This bilingual nurse is able to engage individuals at the "teachable moment" and to actively enroll them into the program. The nurse also works with hospital-based providers to improve care management and discharge planning.

The Program's most difficult challenge has been the triple "E" approach - Engage, Educate and Empower - individuals to self manage and self advocate. This culturally diverse and economically disadvantaged group has presented unique challenges for the program Nurse Care Managers. Through their care, compassion, dedication, persistence and creativity over the past three years, program participants have had a decline in unnecessary hospitalization, improved access to providers, services and care in the community, and most importantly improved quality of life.

For calendar year 2003, a subgroup of 45 Connect CARRE enrollees experienced $1,000,000 less in acute hospitalization when compared to a control group of 45 recipients who were eligible but refused enrollment. The 2003 per member per month (PMPM) for these enrollees was $3,395 compared to a PMPM of $4,995 for those non-enrollees. Preliminary program measures have indicated an increase in home and community based services, behavioral health visits and pharmacy utilization. The enrollee satisfaction survey is ongoing, and preliminary results are very positive for improving quality of life and self-management. The program disease specific measures for Diabetes, Congestive Heart Failure, Sickle Cell Anemia, Chronic Obstructive Lung Disease and Depression for the 45-member cohort for 2003 are encouraging and will serve as a quality improvement focus.

Department of Health Ocean State Immunization Coalition for Flu and Pneumonia Immunization in Community

The Ocean State Adult Immunization Coalition is a joint effort led by DOH, and includes DHS, Rhode Island Quality Partners, long-term care and home care agencies and the Visiting Nurses Association. The group is work-ing to improve flu and pneumonia immunization rates for the over-65 and high-risk under-65 populations. This year the group made significant outreach to employer groups to improve immunization rates in the work force, in particular those agencies that provide adult and child day care.

ENHANCED HOME HEALTH AGENCY REIMBURSEMENT PROGRAM

Purpose of Program

The purpose of the enhanced reimbursement program is to provide additional reimbursement when standards beyond minimal licensing requirements are met.

Specific Enhancements

Additional enhancements can be achieved for the following:

- Shift differential (to improve access during off-hours)
- Staff Education (complete 14 specific in-service programs per year)
- High acuity client by modified MDS assessment every 6 months
- State Accreditation
- National Accreditation (JCAHO-CHAPS-COA)

ADULT HEALTH PROGRAMS & INITIATIVES - CONTINUED

State Accreditation Process

- Agency completes application for accreditation
- DHS and DEA provide a team of professionals to conduct site visit
- Agency is evaluated according to accreditation standards for: client satisfaction; performance improvement process; development of and compliance to care plan, response to referral and client's changing level of service needs; personnel development; claims and reimbursement

Current Status

- 49 of 64 Licensed Home Care Agencies have applied for and receive enhanced rates
- 43 Home Care Agencies participate in Staff Education to improve worker and client satisfaction
- 36 Home Care Agencies have achieved accreditation status
- 21 Home Care Agencies have achieved National Accreditation
- 14 JCAHO / 5 CHAP / 2 COA
- 13 Home Care Agencies have achieved State Accreditation
- 2 Home Care Agencies receive auto enhancements only
- 12 Home Care Agencies do not participate in this program
- DHS provides Technical Assistance to Home Care Agencies to assistagencies in performance improvement

QUALIDIGM TARGETED HOSPITAL EXPENSES REDUCTIONS INITIATIVES

The Center for Adult Health in conjunction with Qualidigm (the organization which contracts with the Department of Human Services to perform Professional Review Activities) has completed several initiatives that will improve quality of care, care coordination and quality of life for chronically ill Medicaid beneficiaries, while reducing unnecessary hospital expenses.

These initiatives include:

- Addition of the regional tertiary care hospitals in Massachusetts and Connecticut to routine length of stay (LOS) review
- Addition of a Disease Management-Continuing Care Nurse on site at Rhode Island Hospital where 35% of hospital admissions occur, to identify candidates for Connect CARRE, facilitate discharge planning to shorten length of stay (LOS), coordinate follow-up with primary care providers, and reduce unnecessary readmissions to inpatient and ER.
- Analysis of emergency room psychiatric admissions to identify unmet needs for this population, and making recommendations to create alternative providers and settings to meet these needs in the community
- Adoption of the Medicare guidelines and process for identifying and reducing premature discharges which provided quality improvement opportunities.
- Adopting a stricter length of stay (LOS) criteria set.

ADULT HEALTH PROGRAMS & INITIATIVES - CONTINUED

DRUG UTILIZATION REVIEW

The Drug Utilization Review (DUR) Board oversees pharmaceutical use in Medicaid, in order to ensure that medications are utilized appropriately and cost-effectively. The Board is made up of physicians, pharmacists, and other health care professionals working in Rhode Island. The Board meets quarterly. In addition, DHS conducts prospective reviews through online edits and audits and at point-of-service discussions with patients to ensure that duplicate or interacting medications are not prescribed. Health Information Designs, a contractor, conducts retrospective utilization review for Medicaid-payable prescription drugs, tracks trends in prescriptions, and provides information to help physicians improve their prescribing practices.

MEDICAL TRANSPORTATION

Many elderly citizens and people with disabilities receiving Medical Assistance need assistance with transportation to access medical services. Individuals are encouraged to seek help from friends, neighbors and family members. In addition, many health centers, community agencies and volunteer groups provide rides. When none of these are available, the state can provide assistance.

The Rhode Island Public Transportation Authority (RIPTA) provides "no fare" and free ride programs to Medical Assistance enrollees who apply for a RIPTA Senior/Disabled Bus Pass. The RIDE Program provides door-to-door transportation to medical appointments to people over age 60 and individuals with disabilities. Medicaid also covers wheelchair van transportion for those recipients who require transportation to medical appointments and cannot access other services. This service served 1,752 people in FY 2005.

CENTER FOR ADULT HEALTH

POPULATIONS & SERVICE EXPENDITURES

ADULTS WITH DISABILITIES

Population Characteristics

Medicaid's average monthly caseload of adults with disabilities (age 21 to 64) was 25,820 in fiscal year 2005. This is approximately a two percent increase from the previous year. By disability, disease or illness, adult Medicaid enrollees with disabilities fell into one of three population groups:

- Individuals with developmental disabilities and mental retardation;
- Individuals who are physically disabled and or chronically ill, and
- Individuals who are severely and persistently mentally ill.

These three groups have different health care needs, and, depending on each individual's need for care, services are provided in the community, in a nursing home or other facility.

Services and Expenditures

In FY 2005, Medicaid spent $599 million on services for adults with disabilities, an 7.5 percent increase over the previous year. The average per client per month spending (PCPM) was $1,869. **Exhibit 14** shows the average monthly per client Medicaid spending by service provider categories in fiscal years 2004 and 2005.

The average monthly expenditures per capita grew two percent between fiscal year 2004 and 2005. Average monthly expenditures per capita increased in every service provider category, except home and community based services. The decrease in home and community based service expenditures resulted from the movement of claims payments for these services to the MMIS, which improves the ability to account for expenditures by date of service. The three largest expenditure categories, accounting for over 70 percent of all expenditures, were as follows:

- $681 PCPM for home and community based services
- $342 PCPM for hospitals (including inpatient, outpatient and emergency department services)
- $298 PCPM for pharmacy

ELDERLY ADULTS

Population Characteristics

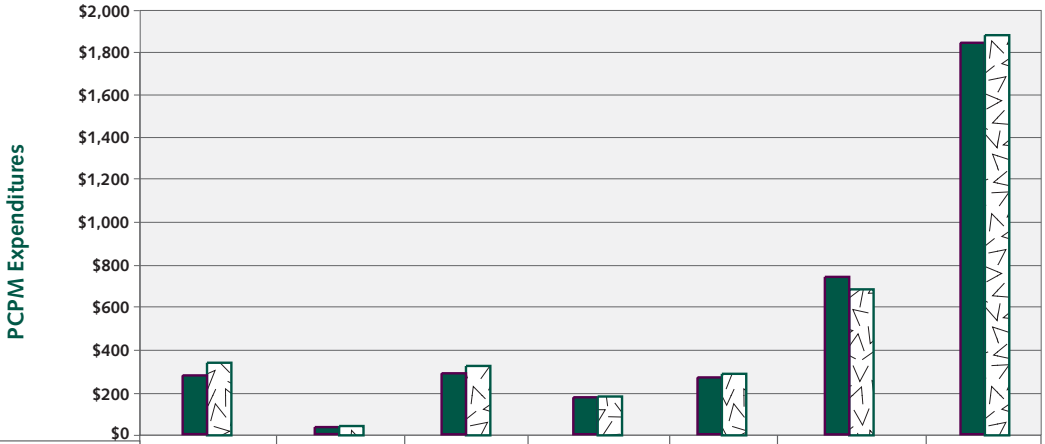
In fiscal year 2005, the average monthly caseload of recipients age 65 and over was 19,784 a less than one percent increase over FY 2004.

Services and Expenditures

In fiscal year 2005, Medicaid spent over $441 million on services for aged recipients, an increase of 3.8 percent over FY 2004. Fiscal year 2005 PCPM expenditures for elderly recipients totaled $1,787, a 3.5 percent increase. Exhibit 15 indicates that $1,209 PCPM for elderly recipients were for institutional services, or approximately 70 percent of total expenditures. Monthly per capita costs for prescription drugs, the second largest category of monthly expenditures for the elderly population, rose 7.5 percent in fiscal year 2005.

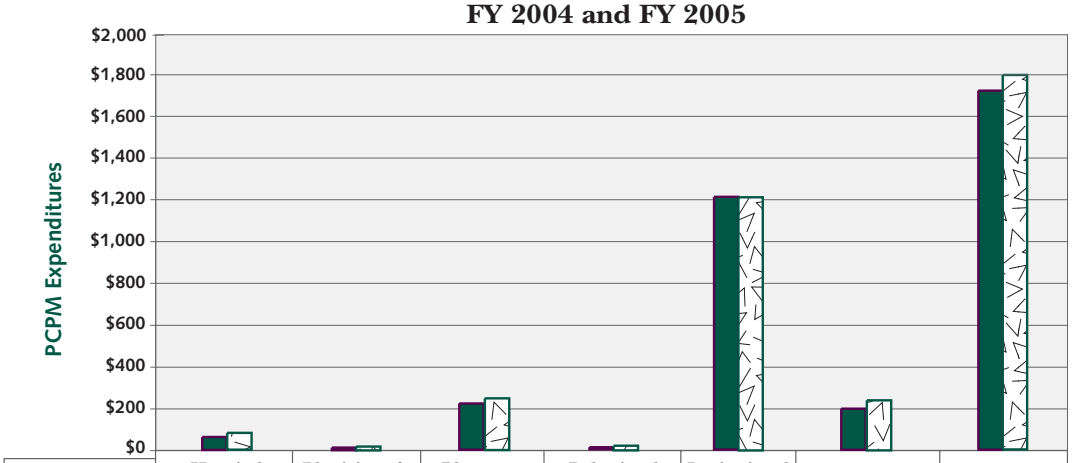
ADULT HEALTH SERVICES & EXPENDITURES - CONTINUED

EXHIBIT 14
Adults with Disabilities
PCPM Program Expenditures by Service Provider
FY 2004 and FY 2005



Service Provider Category	Hospital	Physician & Other Professionals	Pharmacy	Behavioral Health	Institutional	Home & Community Based Services	PCPM
FY 2004	$285	$47	$298	$182	$277	$745	**$1,834**
FY 2005	$342	$48	$325	$185	$289	$681	**$1,869**

EXHIBIT 15
Elderly Adults
PCPM Program Expenditures by Service Provider
FY 2004 and FY 2005



Service Provider Category	Hospital	Physicians & Other	Pharmacy	Behavioral	Institutional	Home & Community Based Services	PCPM
FY 2004	$64	$12	$224	$14	$1,213	$199	**$1,725**
FY 2005	$76	$13	$241	$15	$1,209	$233	**$1,787**

CENTER FOR CHILD & FAMILY HEALTH

PROGRAMS & INITIATIVES

The Center for Child and Family Health (CCFH) administers the delivery of health services for the following

- Medicaid/SCHIP populations:
- Children under age 19 living in families with incomes less than 250 percent of FPL
- Pregnant women with incomes less than 250 percent of FPL
- Parents of children with family incomes less than 185 percent FPL
- Children with special health care needs, including those eligible for Medical Assistance due to:
  - Substitute care (foster care) (up to age 21)
  - Subsidized adoptive placements (up to age 21)
  - Supplemental Security Income (SSI, up to age 21)
  - The Katie Beckett provision (up to age 18)

These populations receive health care services through either the RIte Care program or traditional fee-for-service Medicaid. Over the past two years, DHS has initiated strategies designed to stabilize growth in the RIte Care program, both by implementing RIte Share, Rhode Island's premium assistance program for employer-sponsored health care coverage, and through the implementation of cost-sharing for RIte Care and RIte Share families. In addition, since November 2000, the Department has worked to contain the growth in expenditures for services and enhance the quality, access and coordination of care for children with special health care needs by transitioning them from Medicaid fee-for-service into RIte Care. Beginning in 2001, the Department began operation of the CEDARR Initiative, a family-centered system of evaluation, care planning, family information and support and timely access to health services which augments the care of children with special health care needs.

RITE CARE FOR CHILDREN & FAMILIES

RIte Care is Rhode Island's Medicaid managed care program for low-income and uninsured children, parents, and pregnant women. RIte Care was implemented in 1994 under a Section 1115(a) Waiver. The Waiver allowed Rhode Island to create a comprehensive, coordinated health care delivery system through competitively procured contracts with licensed managed care organizations accredited by the National Committee on Quality Assurance. RIte Care implementation changed the nature of the delivery system for Medicaid enrollees by enrolling members in a health plan, providing every member with his or her own primary physician and implementing standards for provider accessibility and responsiveness. A core goal was to increase access to appropriate, timely primary care, including preventive care and "sick visits", thus decreasing the reliance on less appropriate emergency department visits and reducing avoidable hospitalizations.

RIte Care has increased enrollee access to health care and improved health outcomes, while containing the growth of costs. Not all managed care is alike: RIte Care has several key design features specified in the Health Plan contracts that are quite different from health plans' commercial contracts. These design features, along with oversight and monitoring by the State, are key ingredients in RIte Care's success. Evaluations of RIte Care have shown very significant improvements in participants' access to timely primary care as well as specialty care. Choice has been expanded by providing access to a much wider network of primary care and specialist providers than had been available in fee-for-service Medicaid. Overall, 97 percent of enrollees indicate that they are very satisfied or satisfied with RIte Care - a percentage that has remained relatively consistent for the past eight years.

CHILD & FAMILY HEALTH PROGRAMS & INITIATIVES - CONTINUED

RIte Care has had a significant impact on the uninsured in Rhode Island. At its inception, 11.5 percent of the total population and 9 percent of children were uninsured. In 2000, the uninsured population in Rhode Island had dropped to 6.2 percent and 2.4 percent, respectively, the lowest in the nation. Unfortunately, Rhode Island's uninsured population increased to 11.4 percent of the total population and 7.4 percent of children in 2004, largely as a result of the reduction in employer-sponsored health care coverage.

As of June 30, 2005, 125,251individuals were enrolled in RIte Care. This total includes 2,200 children in substitute care and 4,001 children with special health care needs who were enrolled in NHPRI. Health Plan enrollment as of that date was distributed as follows:

NHPRI: 74,630

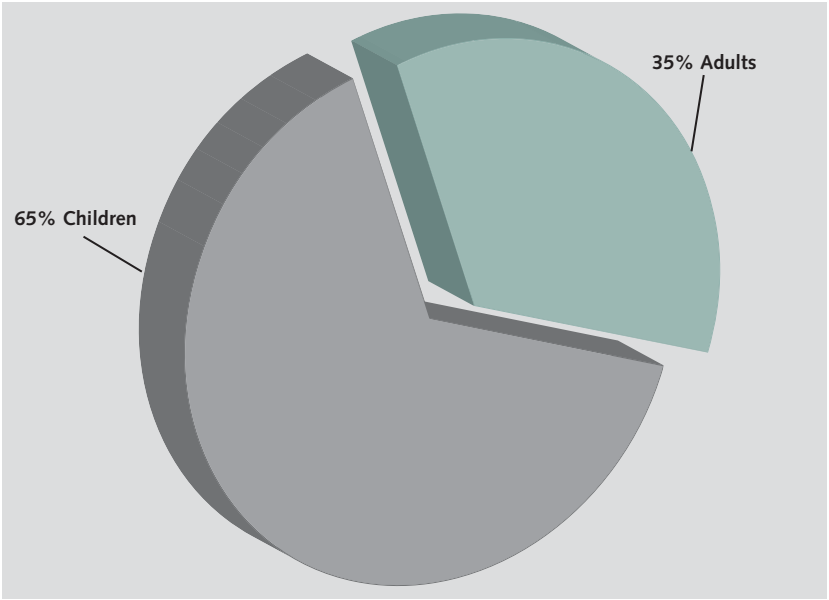
United: 36,764

Blue Chip. 13,857

The above numbers are based on enrollment at a "point in time," thus they vary from the average monthly caseload figures that are reported elsewhere in this document.

Exhibit 16 indicates that nearly two-thirds (65%) of 125,251 RIte Care enrollees were children.

EXHIBIT 16
RIte Care Population Percent Children vs. Adults
As of June 30, 2005
n=125, 251



CHILD & FAMILY HEALTH PROGRAMS & INITIATIVES - CONTINUED

RITE SHARE FOR CHILDREN & FAMILIES

The RIte Care Stabilization Act of 2000 established the RIte Share program, a combined Medicaid/SCHIP premium assistance program intended to support families in their efforts to obtain or maintain private, employer-sponsored health insurance. RIte Share pays (all or part of) an eligible families employer-based health insurance cost, as long as that cost is less than a family's cost of coverage under RIte Care, in other words, if it is more "cost-effective" for the State to pay the employee's share of the employer-sponsored premium than to pay the RIte Care premium. Enrollment in RIte Share is mandatory for Medicaid-eligible individuals whose employer offers an approved health plan. As of January 2002, 117 employers were approved for participation in RIte Share. Since the program began, 1,060 employers have been approved for participation in RIte Share. As of January 2006, 506 employers employed active RIte Share members.

Since RIte Share program inception, DHS has been transitioning RIte Care members into RIte Share. At the time RIte Share became mandatory, DHS estimated that there were 7,000 workers, employed by 4,500 companies, who potentially were eligible to be transitioned to RIte Share. However, not all workers are eligible for commercial health insurance through their employers because of, for example, part-time employment or probationary periods.

In order to transition a RIte Care member to RIte Share, employers must provide DHS with information about their health insurance plan and employee contributions. Changes in the commercial health insurance market present additional challenges to RIte Share. For example, more and more employers are adopting health plans with front-end deductibles and greater differentials in coverage levels for in-network benefits. An employer can mitigate large rate increases through the magnitude of deductibles. For example, a $200 deductible could reduce the premium rate by, say, 3 to 4 percent, whereas, a $750 deductible could reduce the premium rate by, say, 9 or 10 percent. While plan design changes can mitigate the cost of commercial coverage to a certain extent, the cost of coverage may still prove to be too much for employers (and for employees).

As of June 2005, 5,894 individuals were enrolled in RIte Share. In total, RIte Share saved an estimated $4.5 million ($2.0 million state) in SFY2005.

COST SHARING FOR CHILDREN & FAMILIES

The RIte Care Stabilization Act of 2000 also mandated cost-sharing for RIte Care and RIte Share families with family income above 150 percent of the FPL ($24,135 for a family of three). As of August 1, 2002, state law mandated that cost-sharing be raised to approximately five percent of FPL. In SFY 2005, the cost-sharing per family ranged from $61 to $92 per month.

Monthly premiums are collected in two ways:

- For RIte Care, DHS sends a bill and the family pays DHS directly by mailing a check or paying in the community at businesses that have been approved to accept RIte Care premium payments
- For RIte Share, DHS deducts the monthly premium from the amount it reimburses the member for the employee's share of employer coverage.

As of July 5, 2005, 5,392 families (13,317 individuals) were subject to cost-sharing or about 10 percent of all RIte Care and RIte Share enrollees. Any family who is two months in arrears is disenrolled from coverage and can not re-enroll for four months unless the family's income drops below 150% FPL. An average of 140 families a month are sanctioned for failure to pay premiums. In total, $3.58 million ($1.6 million state) were collected from family cost sharing in SFY 2005.

TRANSITIONING CHILDREN WITH SPECIAL HEALTH CARE NEEDS INTO RITE CARE

Children in Substitute Care

In FY 2001, RIte Care began enrolling children in substitute care. Children in substitute care are categorically eligible for Medicaid, but had remained in fee-for-service because of concerns about how managed care would address their needs. Historically, 70 percent of these children had previously been RIte Care members. In preparation for the RIte Care enrollment of children in substitute care, the Department of Children, Youth and Families (DCYF) and DHS established governing principles for the partnership and invited health plans to participate. Currently, only NHPRI enrolls children in substitute care.

The partnership between DHS, DCYF and NHPRI facilitated several system changes. The behavioral health provider network available to children in substitute care was substantially strengthened by including all DCYF active and specialty behavioral health providers in the NHPRI behavioral health provider network, as well as the addition of specialized behavioral health services required by these children. The DCYF and NHPRI have developed a capability that enables data exchange on a daily basis. This exchange provides NHPRI with current placement information on these children and gives DCYF the name of each child's current primary care provider. During SFY 2005, an average of 2,143 children in substitute care were enrolled in RIte Care. This includes over 200 children who have returned to Rhode Island for care from out-of-state placement.

Children in SSI, Katie Beckett and subsidized adoptive placements

During SFY 2005, an average monthly caseload of 9,261 children with special health care needs (CSHCN) including children in Supplemental Security Income (SSI), Katie Beckett and subsidized adoptive placements, received health care through Rhode Island Medicaid on a fee-for-service basis. Over eighty percent of these children qualified for Medicaid due to SSI eligibility, which is based on the family's income and the child's health status. or qualified under the "Katie Beckett" provision, where eligibility is based upon the child's (not the parents') income and resources and the determination that the child needs an institutional level of care and the cost of caring for the child at home is less than the cost of care in an institution. The remainder of the non-RIte Care enrolled children with special health care needs were Medicaid-eligible by virtue of their qualification under Rhode Island's adoption subsidy program.

A Governor's budget initiative in FY 2003 directed DHS to design a service delivery strategy that would allow Medicaid eligible children with special health care needs to be transitioned from fee-for-service Medicaid to RIte Care and have their routine and specialized health care needs met through the participating health plans.

Based on the successful enrollment of children in substitute care, the State believed children with special health care needs could benefit from improved access to care and care coordination afforded through RIte Care by utilizing a service delivery strategy focused on the children's unique needs, the strengths of the family and coordination of services. Enrollment in RIte Care expands provider availability and access to quality, timely provision of services. Slowing the rate of cost increases is an anticipated by-product of improved care.

CHILD & FAMILY HEALTH PROGRAMS & INITIATIVES - CONTINUED

Families of CSHCN can voluntarily enroll their Medicaid eligible child in RIte Care through Neighborhood Health Plan of Rhode Island (NHPRI). DHS requires that NHPRI offer specialized care management and coordination services for CSHCN. NHPRI conducts initial screenings of all newly enrolled CSHCN and offers either short-term care coordination or intensive case management depending on the child's medical and behavioral health care needs. Enrollment in NHPRI is available to Medicaid eligible children with special health care needs who do not have other commercial (third party) health insurance.

In SFY 2005, an average monthly caseload of 3,831 children in SSI or Katie Beckett and children in subsidized adoption were voluntarily enrolled in RIte Care by their families. Of those families offered enrollment in NHPRI, approximately 68% have chosen to enroll their child. In other states, voluntarily enrollments has yielded only a 20-30% participation rate. In Rhode Island, families have expressed significant satisfaction with NHPRI's care management program as well as the robust provider network, which provides enhanced access to primary and specialty care providers. CSHCN also have access to RIte Care "Out of Plan" services which are provided on a fee-for-service basis. Examples of "Out of Plan" services include CEDARR Family Centers, CEDARR direct services and dental care.

CEDARR FAMILY CENTERS

The CEDARR Family Center (CFC) serves as a family-centered source of information, clinical expertise, connection to community supports and assistance to aid the family in meeting the needs of Children with Special Health Care Needs (CSHSN). CEDARR stands for: Comprehensive Evaluation, Diagnosis, Assessment, Referral and Re-evalua-tion. The CEDARR initiative links families to services across public programs and community supports based on a comprehensive assessment of the child and family's needs.

The Leadership Roundtable on children with special health care needs adopted a statewide vision in 1999, which states, "All Rhode Island Children and their families have an evolving, family-centered strength-based system of care, dedicated to excellence, so they can reach their full potential and thrive in their own communities." The outcome of this was a plan in the year 2000 to develop and establish the CEDARR Family Centers, the first of which opened its doors in April 2001.

Services provided through the CEDARR Family Center are designed to identify the appropriateness of care, sup-port a more family-centered system of care, maintain clinical excellence, improve outcomes, and promote overall cost effectiveness for Medicaid-eligible children with special health care needs. In addition, the CEDARR initiative established the means to support new and expanded services in critical areas that currently do not exist or are limited. These services are referred to as CEDARR direct services.

The CEDARR Family Center provides both basic services and supports to families, access to specialized clinical evaluations, and coordination of services. The CEDARR Family Center will work with the child and family to assess current circumstances and identify with the family community services and supports that will assist the family in supporting their child with special health care needs in the home and community.

A Family Care Plan may be developed for some families and could include CEDARR direct support and enhanced services. The CEDARR Family Center will make referrals for all services and supports determined to be necessary for the child and family, and will help coordinate arrangements for CEDARR direct services. Family Care Coordination assists the family in accessing appropriate services.

CHILD & FAMILY HEALTH PROGRAMS & INITIATIVES - CONTINUED

In FY 2005, three CEDARR Family Centers were in operation around the state and served 1,532 children and families. During SFY 2005, 1,817 children were served through a CEDARR Family Center. CEDARR Family Centers served children and families from 39 cities and towns in Rhode Island.

One of the key responsibilities of the CEDARR Family Center is to identify gaps in the current array of services available to meet children's and families' needs, as well as to identify capacity shortfalls. When fully implemented, CEDARR direct services will improve access to a wider continuum of care for children with special care needs. The following CEDARR direct services are being made available when included in a CEDARR Family Care Plan.

CEDARR Direct Services

Home Based Therapeutic Services

Since the mid-1990's, Medicaid eligible children with special health care needs have been receiving Home - Based Therapeutic Services (HBTS) under the provisions of Early Periodic Screening, Diagnosis and Treatment. In February of 2003, the Department of Human Services (DHS) issued certification standards for provider agencies of home-based services. Currently, there are 15 certified HBTS provider-agencies across the state. DHS continues to maintain an open application process for any interested party wishing to become certified as an HBTS provider-agency.

HBTS represents an array of therapeutic services designed to reduce and/or ameliorate deficits in cognitive, communication, psychosocial, and physical functioning in children with special health care needs. This therapeutic service is intended to maintain, stabilize and/or improve adaptive functioning of these children. HBTS is often indicated because children diagnosed with moderate to severe physical, developmental, behavioral or emotional conditions require health and related services beyond those required by children generally.

HBTS is unique in that services are provided in children's homes and community settings by paraprofessionals under the direction of licensed health care professionals. Treatment is therapeutically based upon identification of treatment objectives, specified methods of intervention, and measurable objectives. Participation of parents or caregivers is required. HBTS provider-agencies are an important resource for CEDARR Family Centers. Typically, families are referred to HBTS following a CEDARR Family Center assessment and treatment recommendation.

Over the past year, HBTS provider agencies have served about 416 children. The average client received seventeen hours of HBTS services per week. A treatment plan lasts for 6 months and can be renewed as necessary.

The age distribution of children receiving HBTS have remained relatively constant over the years. Utilization of children by age group for the past year was as follows: 0 - 4 years old represent 9 percent; 5 - 9 years old represent 36 percent; 10 - 14 years old represent 39 percent; and 15 - 19 years old represent 15 percent of the caseload. Their special health care needs were as follows: 9 percent have medical/physical conditions; 6 percent have developmental conditions; 39 percent have behavioral health conditions; 28 percent have autism spectrum conditions and 18 percent have other conditions.

Kids Connect (formerly known as Therapeutic Child and Youth Care)

Kids Connect provides Medicaid funding for specialized therapeutic supports to allow children with significant physical, developmental, behavioral or emotional conditions to participate in typical child and youth care settings. This program features an "inclusive" model, allowing children with special needs to participate in child and youth care settings with peers who are typically developing.

DHS released certification standards for the Kids Connect Program in spring of 2003. Four providers have been certified and DHS is recruiting additional providers in 2006. The DHS goal is for Kids Connect is to be available on a statewide basis for all Medicaid-eligible children and families needing this service. In SFY 2005, 53 children received Kids Connect services.

PERSONAL ASSISTANCE SERVICES AND SUPPORTS (PASS) PROJECT

In FY 2002, CMS awarded DHS and its partners a Community-Integrated Personal Assistance Services and Supports (PASS) grant. This grant supported the design and implementation of a consumer-directed program for children with special health care needs living in the community. The Center for Child and Family Health released certification standards for this program in August 2004. As of December 2005, three providers have been certified and approximately 60 families are currently receiving PASS services. An additional 250 families are in the process of developing PASS plans and receiving training with an expected service start date in 2006. The PASS program provides services and supports to allow children and youth with special health care needs to grow, develop and live as independently as possible in their homes and communities.

EARLY INTERVENTION

Budget Article 44, effective July 1, 2004, transferred the administration of the State's Early Intervention (EI) System from the Rhode Island Department of Health (HEALTH) to the Rhode Island Department of Human Services (DHS). The transition was officially complete as of January 2005. The Departments of Health and Human Services made a commitment to work together to ensure that there were no disruptions to any child's service. DHS took many actions to assure that the process went as smoothly as possible, including informational mailings to EI families and other stakeholders, surveys, site visits, training and orientations and the transferring of three staff members from the Department of Health to DHS. Other efforts included meetings and communications with other stakeholders, surveys of families utilizing EI services, site visits to EI providers and technical assistant to ensure appropriate reimbursement to EI providers.

In addition to Article 44, an insurance mandate was passed in the SFY 2004 legislative session (Article 22). Article 22 mandated that all commercial insurers licensed in Rhode Island (excludes self-insured groups) reimburse certified EI providers for all EI services pro-vided to eligible children and families to a maximum of $5,000 per calendar year per child. Also mandated was that this benefit would not include co-payments or deductibles for families and would not be applied to any annual or life-time maximum benefit contained in the policy or contract.

DHS will continue to ensure that quality services are provided to children and families in Rhode Island through Early Intervention providers throughout the state. This transition is an opportunity to strengthen a valuable service to chil-dren with special health care needs.

SCHOOL-BASED HEALTH SERVICES

A significant percent of the children who receive special education services in Rhode Island are Medicaid eligible. All Rhode Island school districts are participating Medicaid providers. The DHS works with Local Education Agencies (LEAs) and the Department of Education to maximize local schools' ability to receive Medicaid funding for needed medical and dental care provided to Medicaid eligible students. In 2004, DHS published the Medicaid Direct Services and Administrative Claiming Guidebooks for Local Education Agencies. The purpose of these guidebooks is to assist LEA personnel in implementing and maintaining a Medicaid reimbursement program for services provided by or for Local Education Agencies.

CHILD & FAMILY HEALTH PROGRAMS & INITIATIVES - CONTINUED

LEAD CENTERS

The Department monitors and oversees three Certified Lead Centers according to the certification standards developed in 1998 and revised and reissued in 2002. Certified Lead Centers assist families through intensive case management, coordination of housing inspections, relocation assistance, family education, training on cleaning techniques, referrals to medical, legal, nutritional, early intervention, special education, intensive environmental cleaning and other services. DHS reimburses for window replacement costs in the homes of RIte Care enrolled children with significant lead poisoning. In FY 2005 the Lead Centers provided services to 109 children.

The three Certified Lead Centers are:

Blackstone Valley Community Action Program
32 Goff Avenue
Pawtucket, RI 02860

West Bay Community Action Program
205 Buttonwoods Avenue
Providence, RI 02906

St. Joseph Hospital Lead Center
21 Peace Street
5th Floor East
Providence, RI 02907

DRUG COURT

The Rhode Island Family Court, Attorney General, Public Defender, DCYF, MHRH, DOH and DHS collaborated to plan and develop the Rhode Island Family and Juvenile Drug Court. The Juvenile Drug Court grew out of a recognized need for a therapeutic approach to nonviolent juveniles whose involvement in Family Court is attributable to their dependency upon alcohol and other drugs. In addition, there is evidence that a specialized court can enhance public safety by breaking the cycle of recidivism.

Juvenile Drug Court was launched in December 1999. In FY 2005, fifty-three (53) participants were admitted to the program. Forty-four (44) graduated during the year and nine were terminated. Through a series of amended administrative orders, the program was expanded from Providence and Bristol Counties to cover juveniles living anywhere in Rhode Island.

RHODE ISLAND ORAL HEALTH ACCESS PROJECT

The Robert Wood Johnson Foundation awarded Rhode Island $940,000 for a three year period for the Rhode Island Oral Health Access Project. An additional $940,000 in federal Medicaid matching funds was leveraged by the state, bringing the total investment to $1.88 million. A portion of the funds are being used by the Department of Human Services, Center for Child and Family Health to restructure the Medicaid dental delivery system to improve access to dental care with emphasis on preventive and primary care, while containing the growth in costs to the current trend rate. This will allow DHS to transition from a payer of claims to a purchaser of dental services (through a competitive bid process) by contracting with a dental plan or dental benefits manager (DBM) to administer the benefit. In collaboration with a DBM Workgroup, project management staff has made great strides toward this end and released bid specifications in December 2005. Children born on or after May 1, 2000 will be enrolled in the DBM beginning May 1, 2006. It is the State's intent to "age" children into the program to continue their participation.

CHILD & FAMILY HEALTH PROGRAMS & INITIATIVES - CONTINUED

The second component of the project included awarding RWJF grant funds totaling $737,308 to support increased access to dental care through fourteen programs at eleven Rhode Island organizations. This was accomplished through a unique partnership between the Rhode Island Department of Human Services, the Rhode Island Foundation, and Rhode Island KIDS COUNT. The projects, funded in 2004 focus on:

- Workforce Capacity Development,
- Safety Net Provider Service Capacity Development and
- School-Based Dental Services.

As the third project component, RI KIDS COUNT is managing public engagement efforts to keep the issue of access to oral health services in the forefront for policy makers and the public.

RWJF STATE COVERAGE INITIATIVE PROJECT

In FY 2002, Rhode Island was one of only four states to receive a multi-year demonstration grant from the Robert Wood Johnson Foundation's State Coverage Initiative (SCI) Program. The SCI demonstration grants are targeted to states that are ready to achieve a sizable coverage objective, such as significantly reducing the number of working uninsured or designing a novel coverage model or partnership. Rhode Island's project is designed to reduce the level of uninsured in the state by fully implementing RIte Share. Major grant activities include: (1) conducting a formative evaluation of RIte Share operations to ensure that the program is designed to maximize enrollment and budgeted cost-savings, and using this evaluation to create a "how-to" manual for other states starting premium assistance programs;

(2) developing and implementing a management information system for RIte Share that facilitates monitoring and continuous improvement in the areas of enrollment, cost-effectiveness and access to appropriate, effective health care services; (3) conducting, in partnership with the Department of Health, a statewide survey of patterns in employer health insurance to assess trends from a similar survey conducted in 1999 and to elicit feedback from employers concerning RIte Share; (4) conducting a study of the impact of "churning" (frequent change of coverage status) on access to care for Rhode Island's low-income working population; and (5) in partnership with the Brown Medical School, establishing a research fellowship that will facilitate the application of Brown's significant health services research capacity into Rhode Island Medicaid's design and evaluation.

HRSA STATE PILOT PLANNING GRANT PROJECT

In October 2005, Rhode Island was awarded $398 485 in federal funds from the U.S. Department of Health and Human Services, Health Services and Resources Administration (HRSA) to develop a Pilot Plan for *Providing Access to Affordable Health Care Coverage for All Rhode Islanders*.

DHS is the state's lead agency for administering the project. The project management team has built on the management structure of the Center for Family and Child Health and the project structure of Rhode Island's State Coverage Initiative (SCI) Project outlined above. The project director and project management team leader is the Administrator of the Center for Child and Family Health. Key staff from the Departments of Administration, Health and the new Office of the Health Insurance Commissioner plus the Economic Development Corporation provide advice in their areas of expertise and collaborate as members of the team.

Under the grant, an affordable health insurance product will be designed that is (a) atttractive to small employers, employees, self-employed and individuals, (b) offered by private insurers and (c) not threatened by adverse selection.

CHILD & FAMILY HEALTH PROGRAMS & INITIATIVES - CONTINUED

The product design will based on "principles of affordablility" that have been established to guide the Governor Donald Carceiri's Health Care Agenda:

- Focus on primary care, prevention and wellness
- Encourage use of least cost, most appropriate settings
- Use of evidence based quality care
- Active management of the chronically ill
- Protect members from the cost of catastrophic illness

At the end of the grant period, the project will submit a report to the Governor summarizing its work and the Governor will submit the required report to the Secretary of the U.S. Department of Health and Human Services.

CCFH TRACKING ACCESS, QUALITY & OUTCOMES

In order to measure RIte Care's impact on health care access, quality and outcomes, Rhode Island Medicaid estab-lished the Research and Evaluation Project within the Division for Health Care Quality, Financing and Purchasing. The Research and Evaluation Project evaluates what programs work and how change occurs.

Throughout most of the 1990s, research and evaluation efforts focused on the children and families enrolled in RIte Care. As the RIte Care evaluation began to show that the program had a positive impact on health status and outcomes for the target population, Medicaid began expanding the Research and Evaluation Project to other population groups.

For the past eight years, Medicaid has been measuring RIte Care's access, quality and outcome effects. This has allowed the program to track progress in the health and health care of the population over time. RIte Care enrollees have experi-enced significant improvements in their access to health care and health status, including pri-mary, pediatric, and prenatal care, increased inter-birth intervals, decreased maternal smoking, positive trends in low-birth weight among RIte Care newborns, and increased childhood immunization and lead screening rates as follows:

Decrease in the uninsured population. Rhode Island's coverage expansions have decreased the uninsurance rate of chil-dren. The percentage of uninsured children in Rhode Island had dropped from 12.5 percent in 1995 to 2.4 percent in 2000, the lowest in the nation. Unfortunately, as a result of erosion in employer sponsored coverage uninsured children in Rhode Island increased to 7.4 percent in 2005.

Increased inter-birth interval. An increasing number of women on Medicaid wait at least 18 months between births. The most recent data (2003) complied for Medicaid-enrolled women in Rhode Island showed that 72.1 percent had an inter-birth interval of at least 18 months, compared to 73 percent of women with commercial coverage.

Reduction in smoking during pregnancy. The percent of pregnant women enrolled in Medicaid who smoked during pregnancy has declined from 32 percent in 1993 to 20.2 percent in 2003.

Improved access to prenatal care. In 2003, 84 percent of women enrolled in Medicaid began prenatal care in the first trimester, up from 77 percent in 1993.

Increased adequacy of prenatal care. The number of women on Medicaid receiving adequate prenatal care increased significantly, from 70.1 percent in 1993 to 82.2 percent in 2003. **Births to Teens.** The percentage of births to teens enrolled in Medicaid continued to decline. In 2003, 16.6 percent of Medicaid-covered births were to teen mothers. This represents a decline from 23.2 percent in 1993.

CHILD & FAMILY HEALTH POPULATIONS & SERVICE EXPENDITURES

CHILDREN & FAMILIES IN MANAGED CARE

Population Characteristics

Rite Care-Children and Families

In FY 2005, children under age 19 accounted for 65 percent of the RIte Care average monthly caseload. Approximately three-quarters of the adults were female. Ninety (90) percent of RIte Care members had household incomes below 150 percent of the federal poverty level (FPL), or below $24,135 for a family of three. Twenty-two (22) percent of the population spoke a language other than English as their primary language spoken at home. The second most common language, Spanish, was spoken by 18 percent of RIte Care members.

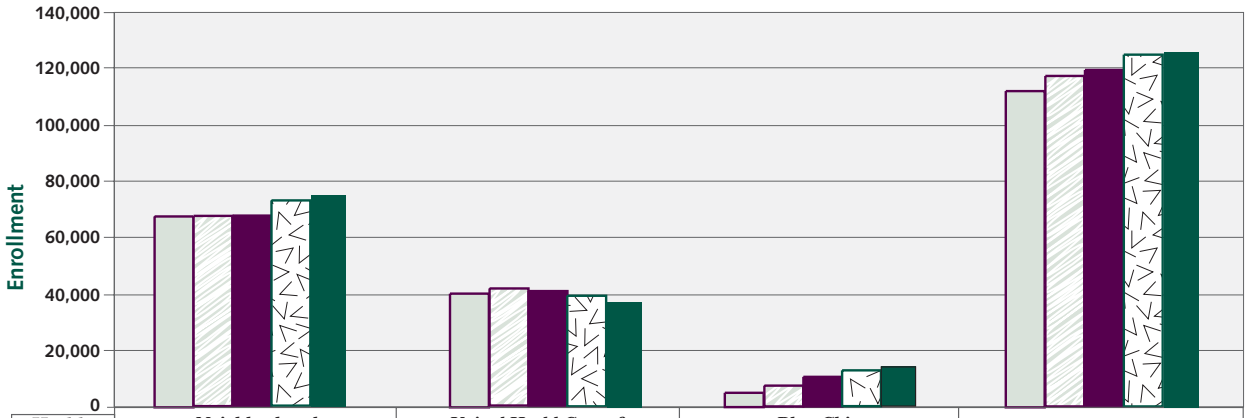
Enrollment

The distribution of RIte Care membership across the three participating health plans is displayed in **Exhibit 17.** At the end of the FY 2005, 60 percent of all RIte Care members were enrolled through NHPRI. United Healthcare and Blue CHiP had 29 percent and 11 percent of RIte Care members, respectively.

RIte Share - Children and Families

- In FY 2005, RIte Share's average monthly caseload was 5,894. Sixty-four (60) percent of the caseload were children under age 18. Based on June 2005 data, of RIte Share's total enrollees:
  - 42 percent were enrolled in a Blue Cross/Blue Shield of Rhode Island product
  - 30 percent were enrolled in United Health Care of New England
  - 8 percent were enrolled in 21 other health care products

EXHIBIT 17
RIte Care Enrollment* by Health Plan
FY 2001 to 2005



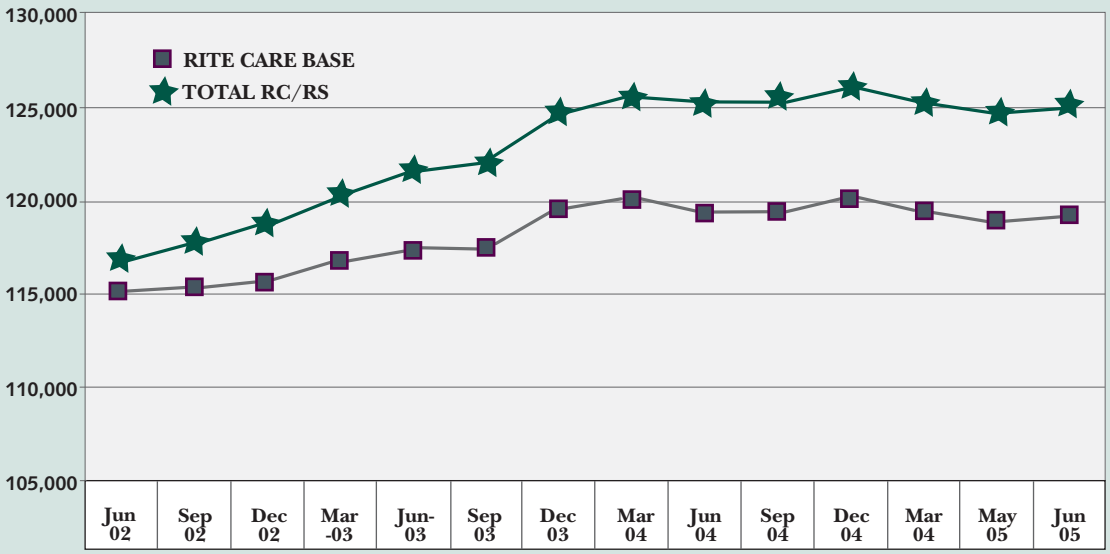
Health Plan	Neighborhood Health Plan	United HealthCare of New England	Blue Chip	TOTAL
2001	67,057	39,964	4,603	111,624
2002	67,410	41,900	7,714	117,024
2003	67,558	41,062	10,637	119,257
2004	72,994	39,147	12,780	124,921
2005	74,630	36,764	13,857	125,251

* Unduplicated count by health plan & Includes children with special health care needs beginning in 2002

CHILD & FAMILY HEALTH POPULATION & SERVICE EXPENDITURES - CONTINUED

Exhibit 18 displays combined enrollment trends in RIte Care and RIte Share. Beginning in January 2002, RIte Care enrollment leveled-off as new applicants and existing RIte Care members with access to employer-sponsored health insurance were enrolled in their employer's coverage through RIte Share.

EXHIBIT 18
RIte Care/RIte Share Enrollment Update as of June 30, 2005



Services and Expenditures

Rite Care-Children and Families

In SFY 2005, total Medicaid expenditures for RIte Care children and families were $345 million an increase of nine percent over the previous year. Exhibit 19 displays SFY 2005 average per client per month (PCPM) expenditures by service for children and families in managed care. The total PCPM includes services funded by DHS, DCYF and the LEAs for capitation payments to health plans, additional funds paid to health plans for services provided beyond the capitation package (such as unlimited mental health services), and funds paid directly to providers for services not provided by the health plans (including dental and transportation). Between SFY 2004 and SFY 2005, the total PCPM grew ten percent to $227. The three largest expenditure categories, accounting for over 80 percent of all expenditures, were as follows:

- $120 PCPM for hospital services (including inpatient, outpatient and emergency department services)
- $35 PCPM for pharmacy
- $35 PCPM for physician and other professional services (Note: this category of expenditures decreased by $11 PCPM as a result of health plans reclassifying laboratory and radiology claims to hospital outpatient services between SFY 2004 and SFY 2005.

CHILD & FAMILY HEALTH POPULATION & SERVICE EXPENDITURES - CONTINUED

RIte Share-Children and Families

In SFY 2005, total Medicaid expenditures for RIte Share children and families were $8.0 million, reflecting $7.1 million in premium payments to employer-sponsored health plans to pay the employee share of premiums and $0.9 million for Medicaid services not covered by employer-sponsored coverage. The total per client per month (PCPM) cost of RIte Share coverage was $117 distributed as follows:

- $103 PCPM for the employee's share of employer-sponsored health plan premium
- $14 PCPM for services not covered by the health plan premiums

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

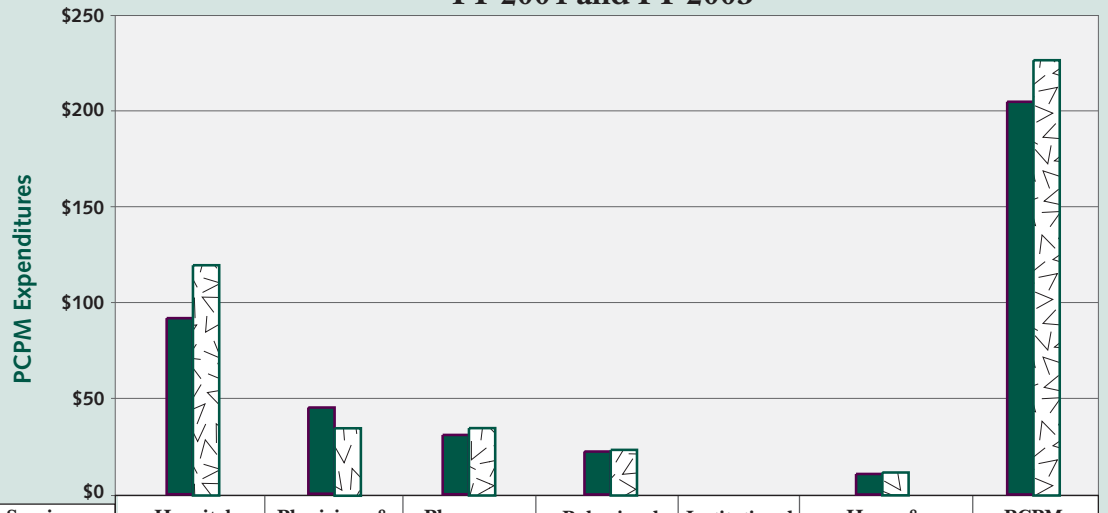
Population Characteristics

Under RI General Laws Section 42.12.27, in FY 2004, The Department of Human Services was instructed to report on expenditures on the following subpopulations within children with special health care needs:

- Children with disabilities (children with SSI or covered under the Katie Beckett provision)
- Children in substitute care
- Children in subsidized adoption.

In the aggregate, an average of 15,235 children with special health care needs were served in Medicaid each month during SFY 2005, an increase of ten percent from the previous year. Children in this subgroup are eligible for Medicaid because they are enrolled in SSI, under the Katie Beckett provision, in adoption subsidy or in foster care (substitute placement).

EXHIBIT 19
Children & Families in Managed Care*
PCPM Program Expenditures by Service Provider
FY 2004 and FY 2005



Service Provider Category	Hospital	Physicians & Other Professionals	Pharmacy	Behavioral Health	Institutional	Home & Community Based Services	PCPM
FY 2004	$93	$46	$32	$23	$0	$12	**$206**
FY 2005	$120	$35	$35	$24	$0	$12	**$227**

*excludes RIte Share

CHILD & FAMILY HEALTH POPULATION & SERVICE EXPENDITURES - CONTINUED

Eligibility for SSI is based on family income and the child's health. Children with special health needs receiving an institutional level of care in the home who do not meet SSI financial eligibility requirements may be found Medicaid eligible if they meet the requirements of the Katie Beckett provision. "Katie Beckett" eligibility is based on: **(1)** the child's income and resources only (not the parents'); and **(2)** a calculation that the cost of caring for the child at home is less than the cost of care in an institution.

Children in substitute care are placed in foster care or group homes under the child protective services of the Department of Children, Youth and Families due to neglect and physical, sexual or emotional abuse. Children in substitute care, up to age 21, are eligible for Medicaid.

A third group of children with special health care needs is made up of individuals under age 21 who have been adopted through subsidized adoptive arrangements. The agreement between the state and the adoptive parents includes a provision indicating that the child will remain Medicaid eligible until he or she turns 21.

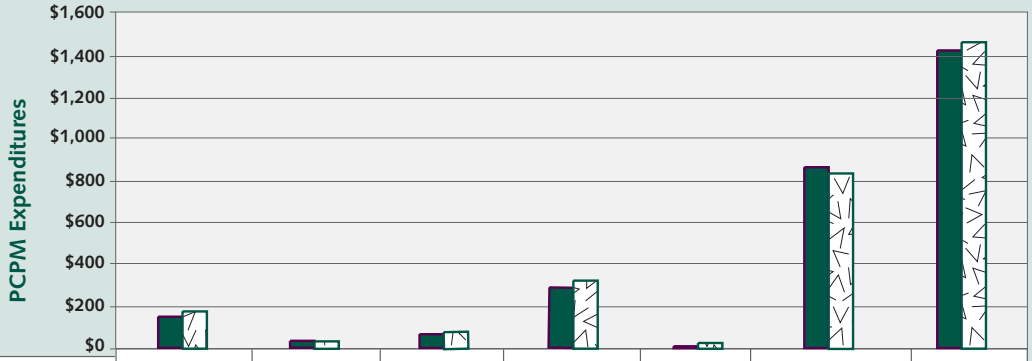
Services & Expenditures

Total Medicaid program expenditures for the aggregate population were $212 million, an increase of ten percent from FY 2004 expenditures. The total per capita per month (PCPM) spending was $1,446. As displayed in **Exhibit 20**, two service provider categories represented almost 80 percent of all expenditures, i.e.:

- $820 PCPM for home and community-based services (including EPSDT services, intensive home-based therapy, private duty nursing, and certified nursing assistant services)
- $316 PCPM for behavioral health services.

As previously stated, expenditures for physicians and other health professionals decreased as a result of health plans reclassifying laboratory and radiology claims to hospital outpatient services.

EXHIBIT 20
Children with Special Health Care Needs
PCPM Program Expenditures by Service Provider
FY 2004 and 2005



Service Provider Category	Hospital	Physicians & Other Professionals	Pharmacy	Behavioral Health	Institutional	Home & Community Based Services	PCPM
FY 2004	$153	$39	$69	$289	$5	$856	**$1,409**
FY 2005	$172	$32	$77	$322	$23	$820	**$1,446**

CHILD & FAMILY HEALTH POPULATION & SERVICE EXPENDITURES - CONTINUED

Exhibit 21 displays the distribution of the three subpopulations, of the total 15,235 children with special health care needs in FY 2005:

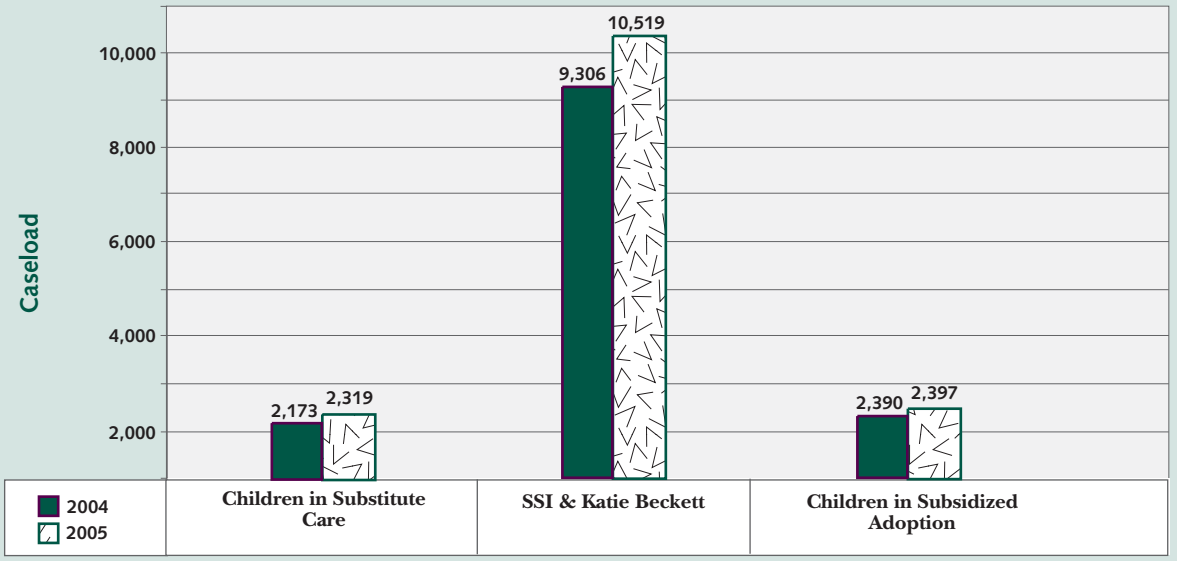
- 10,519 were children in SSI or Katie Beckett
- 2,397 were children in subsidized adoption
- 2,319 children in substitute care

Exhibit 22 displays the distribution of the three sub-populations in terms of total expenditures of $212 million, that is:

- $119 million for SSI and Katie Beckett
- $79 million for children in substitute care
- $15 million for children in subsidized adoption

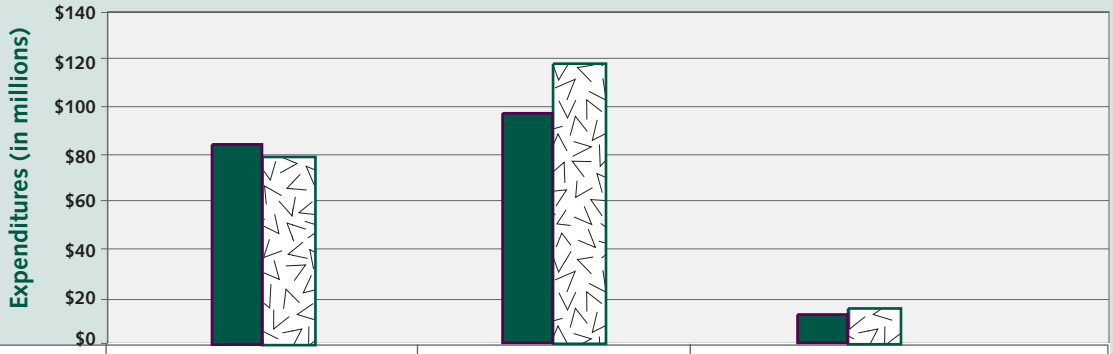
The decrease in expenditures for children in substitute care resulted from a movement of claims processing to the MMIS, which improves the ability to account for expenditures by date of service.

EXHIBIT 21
Caseload Distribution of Children with Special Health Care Needs SFY 2004 and SFY 2005



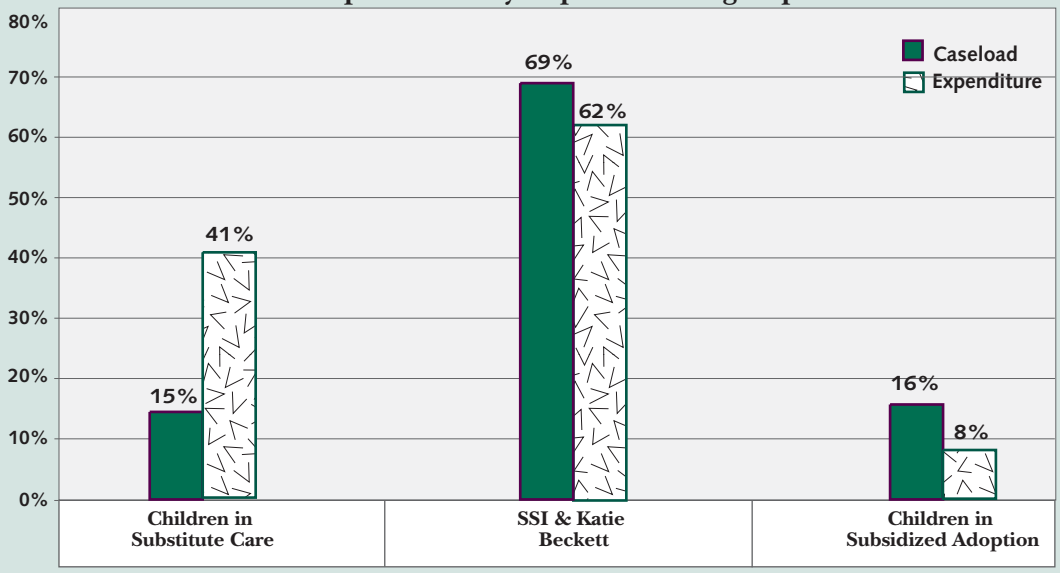
CHILD & FAMILY HEALTH POPULATION & SERVICE EXPENDITURES - CONTINUED

EXHIBIT 22
Expenditures of Children with Special Health Care Needs by Population Subgroup SFY 2004 and SFY 2005 in Millions



	Children in Substitute Care	SSI & Katie Beckett	Children in Subsidized Adoption
2004	$82	$98	$12
2005	$79	$119	$15

EXHIBIT 23
Children with Special Health Care Needs - Percent Caseload vs Percent Expenditures by Population Subgroup SFY 2005

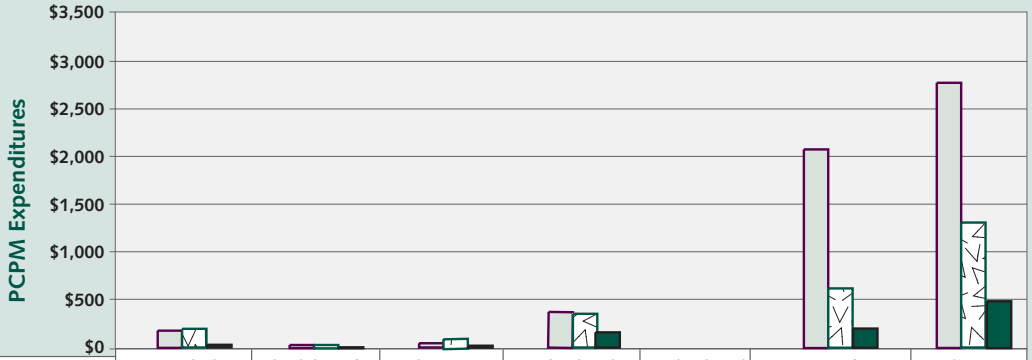


CHILD & FAMILY HEALTH POPULATION & SERVICE EXPENDITURES - CONTINUED

Exhibit 23 compares caseload and expenditures for the three subpopulations. Children in substitute care represent 15 percent of the total special needs population and 41 percent of the expenditures. Children in subsidized adoption represent 16 percent of the population and only 8 percent of the expenditures.

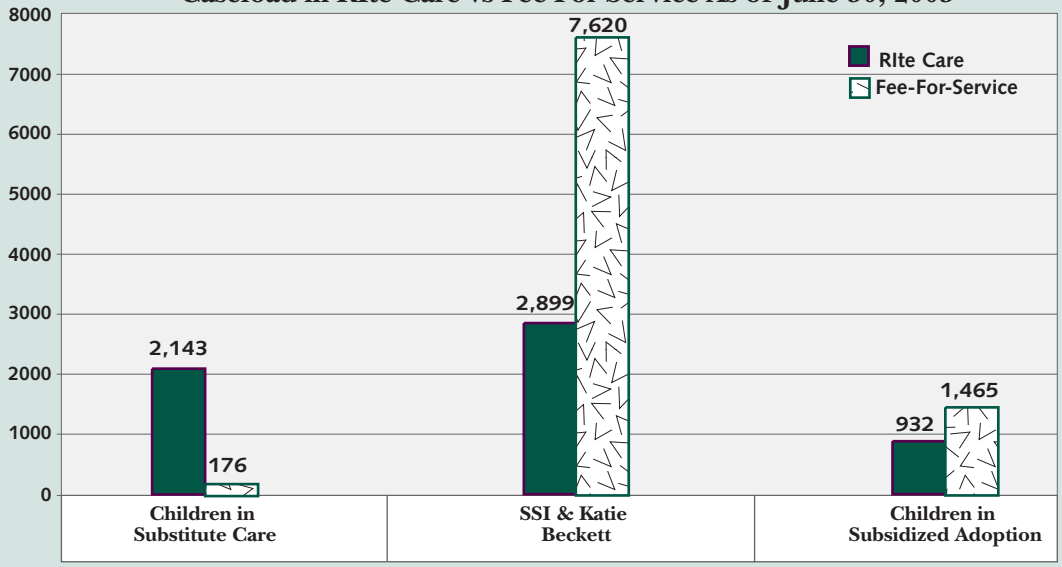
Exhibit 24 compares PCPM expenditures by service provider category. By far, children in substitute care have the highest PCPM at $2,766, a decrease of 11 percent from the previous year. For all three populations, home and community based services represent the largest expenditure category.

EXHIBIT 24
Children with Special Health Care Needs by Population Subgroup PCPM by Service Provider SFY2005



Service Provider Category	Hospital	Physicians & Other Professionals	Pharmacy	Behavioral Health	Institutional	Home & Community Based Services	PCPM
Children in Substitute Care	$190	$46	$69	$384	$0	$2,076	**$2,766**
SSI & Katie Beckett	$205	$33	$91	$350	$7	$619	**$1,305**
Children in Subsidized Adoption	$49	$21	$38	$178	$0	$214	**$501**

EXHIBIT 25
Children with Special Health Care Needs By Subgroup Caseload in RIte Care vs Fee-For-Service As of June 30, 2005



WEB SITE LINKS

Look on the DHS web site: www.dhs.ri.gov for the following links to find more information about topics discussed in this report.

- What is Medicaid?
  - History of Medicaid
- Who is Eligible?
- What Services are covered?
- How is Medicaid Financed?
- How is Rhode Island's Medicaid Budget Determined
  - Caseload Projections & Budget Forecasts
- What is a Waiver?
- Research & Evaluation Project
- How to apply for Medicaid, RIte Care or RIte Share

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- Griffin, Jane. The Impact of RIte Care on Adequacy of Prenatal Care and the Health of Newborns - Ten Year Profile and Trends of Births by Insurance Status, 1993-2002.
- Payne, Christine, Needs Assessment Survey of RI Working-Age Adults with Physical Disabilities and Chronic Health Conditions on Fee-for-Service Medicaid, February 2002.

See http://www.ritecareresearch for a comprehensive library of research reports and issue briefs

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